Petition

81-875

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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

ALABAMA HOSPITAL ASSOCIATION, *et al.*,
Petitioners,

v.

THE UNITED STATES,
Respondent.

PETITION FOR A WRIT OF CERTIORARI
To the United States Court of Claims

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QUESTIONS PRESENTED FOR REVIEW[1]

Department of Health, Education and Welfare (now "Health and Human Services"), and its fiscal intermediary, Blue Cross, took or recouped from Alabama Hospitals $657,000 after a unilateral determination—without a hearing before, during or after it—that these sums had been paid as reimbursement under the Medicare Act for unnecessary medical services. A United States District Court held that these administrative acts and omissions deprived these Alabama Hospitals of their property without due process of law. The United States Court of Appeals for the Fifth Circuit held that the district court had no subject matter jurisdiction, and that Congress in 42 U.S.C. §1395ii had precluded all federal judicial remedies for this unconstitutional deprivation of property. Because the Fifth Circuit construed decisions of the Court of Claims[2] as holding that there was sub-

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[1] The parties to the proceedings in the United States Court of Claims (hereafter "Court of Claims") were the Alabama Hospital Association and certain named Alabama hospital providers, and the United States. Petitioners as plaintiffs in the United States District Court for the Middle District of Alabama (hereafter "Alabama Hospitals"), on December 20, 1974, sued on their own behalf, and on behalf of all private non-profit, private proprietary, and non-federal governmental hospitals located in Alabama (with the exception of one hospital). It was stipulated that the action was properly maintainable and could proceed as a class action pursuant to Rule 23, F.R.C.P. on behalf of all such affected hospitals located and operating in Alabama; and that Petitioners were proper representatives to maintain the class action.

After transfer of this action from the United States Court of Appeals, Fifth Circuit to the Court of Claims (as more fully appears in the "Statement of the Case") and as noted in the opinion of the Court of Claims (App. A, p. 2, n. 3), the action proceeded in the Court of Claims under Rule 63(a) as a "joint action" rather than a "class action" on behalf of the "joint plaintiffs" listed in that footnote.

[2] Notably *Whitecliff, Inc.* v. *U.S.*, 536 F.2d 347 (Ct. Cl. 1976), cert. denied 430 U.S. 969.

ject matter jurisdiction to hear and decide the constitutional claims of Alabama Hospitals, the Fifth Circuit intentionally avoided a decision on the constitutionality of such Congressional preclusion by transferring the cause to the Court of Claims pursuant to 28 U.S.C. § 1406(c).

Conceding that the import of its decision and that of the earlier one of the Fifth Circuit in this litigation "is that Alabama [Hospitals] are unable, in their own stead, to challenge the adverse coverage determinations or the constitutionality of the recoupment procedures," the Court of Claims, nevertheless, entered a summary judgment of dismissal on the ground that it lacked subject matter jurisdiction.

The questions presented are:

1. Does this statute, 42 U.S.C. § 1395ii, strip federal courts of all subject matter jurisdiction to decide such a constitutional question?

2. If so, does this statute violate the due process clause of Amendment V of the Constitution of the United States?

3. Did the court below, erroneously—and in square conflict with holdings of the Fifth Circuit in this and other litigation—hold that Alabama Hospitals have no constitutionally protected property interest in the funds so taken or recouped, because Alabama Hospitals had a theoretical cause of action against their former patients for those funds?

4. Even if this statute, 42 U.S.C. § 1395ii, precludes the exercise of subject matter jurisdiction by the federal courts under 28 U.S.C. § 1331(a), is there jurisdiction to hear and decide such a constitutional claim to procedural due process under the mandamus statute, 28 U.S.C. § 1361?

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OPINION BELOW

The opinion of the Court of Claims of June 17, 1981 is not yet reported and appears as Appendix A; the Order of that Court of October 2, 1981 denying Petitioners' motion to alter or amend judgment and for rehearing, appears as Appendix B.

JURISDICTION

The judgment of the Court of Claims was entered on June 17, 1981; its judgment denying Petitioners' motion to alter or amend or for rehearing, timely[1] filed there, was entered on Oc-

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[1] The Order of the court below of October 2, 1981 recites that the motion of Petitioners to alter, amend or for rehearing was filed on June 28, 1981—within 12 days of the Judgment of June 17, 1981, and within the 14 days prescribed by Rule 151(b) of the Rules of that Court as enlarged by the 5 additional days prescribed by Rule 25(c) when service is made by mail outside the District of Columbia.

tober 2, 1981. This Petition for Certiorari was filed within 90 days of that latter date. This Court's jurisdiction in invoked under 28 U.S.C. § 1255(1).

STATUTORY AND CONSTITUTIONAL PROVISIONS

United States Constitution, Amendment V:

> "No person shall be * * * deprived of * * * property, without due process of law * * *."

42 U.S.C. § 1395ii:

> "The provisions . . . of subsection . . . (h) . . . of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter."

42 U.S.C. § 405(h):

> "(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter."

28 U.S.C. § 1331(a):

> "(a) The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution, laws, or treaties of the United States."

28 U.S.C. § 1361:

> "The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff."

28 U.S.C. § 1406(c):

> "(c) If a case within the exclusive jurisdiction of the Court of Claims is filed in a district court, the district court shall, if it be in the interest of justice, transfer such case to the Court of Claims, where the case shall proceed as if it had been filed in the Court of Claims on the date it was filed in the district court."

28 U.S.C. § 1491:

> "The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, . . . or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * *"

28 U.S.C. § 1651:

> "(a) The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usage and principles of law."

Generally, 42 U.S.C. § 1391, et seq. "Medicare Act."[4]

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[4]The entire "Medicare Act" has not been reproduced.

STATEMENT OF THE CASE

Petitioners ("Alabama Hospitals"), on December 20, 1974, sued in the United States District Court for the Middle District of Alabama ("District Court") on their own behalf, and on behalf of all private non-profit, private proprietary and non-federal governmental hospitals located in Alabama (with the exception of one hospital). Alabama Hospitals sought monetary damages and injunctive and declaratory relief for an asserted wrongful taking or recoupment of their funds without due process of law. It was stipulated that the action was properly maintainable and could proceed as a class action pursuant to Rule 23, F.R.C.P. on behalf of all such affected hospitals located and operating in Alabama; and that Petitioners were proper representatives to maintain the class action. (A copy of this Stipulation is included as Appendix E hereto.)

Defendants in the District Court were the Secretary of the Department of Health, Education and Welfare, now Health and Human Services, and Blue Cross-Blue Shield of Alabama (hereafter collectively "HHS").

Pursuant to the Medicare Act[1], Alabama Hospitals, having agreed with HHS to become providers of medical services for beneficiaries of the Medicare program, looked to HHS for payment through HHS's designated Alabama "fiscal intermediary", Blue Cross-Blue Shield.

Under the statutory plan, HHS may question the coverage of services provided by hospitals and the cost of such services. Non-covered services and charges which exceed "reasonable costs" are not reimbursable. No question of cost, however, is involved in the case at bar.

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[1] 42 U.S.C. §§ 1395, et seq.

Alabama Hospitals, between 1967-1972, received approximately $657,000 in Medicare funds to which HHS had determined they were entitled. This dispute arose because subsequently, by ex parte proceedings without any evidentiary hearing or review—*either before or after a unilateral determination*—HHS found that these funds were overpayments for unnecessary medical services; and thereupon HHS took away these funds from Alabama Hospitals under duress by forcing repayment or by withholding future funds admittedly due Alabama Hospitals.[6]

The District Court, then Judge Frank M. Johnson, Jr., on August 23, 1976, held that this governmental taking, without affording the provider hospitals a hearing *at some point*, violated procedural due process guaranties of the Fifth Amendment of the United States Constitution. The District Court, moreover, ordered that HHS "pay to [Alabama Hospitals] the disputed amounts or . . . undertake evidentiary hearings within a reasonable time."[7]

On appeal from that order, the Fifth Circuit dismissed the HHS appeal; and transferred the cause to the Court of Claims pursuant to 28 U.S.C. § 1406(c). The Fifth Circuit held that the District Court had no federal subject matter jurisdiction under

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[6] In the words of the United States Court of Appeals, Fifth Circuit (Appendix C, pp. A-23—A-26, 587 F.2d at 763):

> "The lawsuit arose out of HEW's recoupment of reimbursement funds paid to provider hospitals for medical services that Blue Cross, plaintiffs' fiscal intermediary, unilaterally determined were unnecessary. The plaintiffs contend that they were constitutionally entitled to a hearing at some point during or after the recoupment process. The district court agreed."

[7] Appendix D. pp. A-27—A-34.

the Administrative Procedure Act[8] or under 28 U.S.C. § 1331(a).[9] It was silent on the assertion that subject matter jurisdiction was also conferred by the mandamus statute, 28 U.S.C. § 1361.[10] This Court denied certiorari. *Alabama Hospital Association* v. *Harris,* 444 U.S. 826.

Thereafter, petitioners refiled, *mutatis mutandis,* their complaint in the District Court as a petition in the court below, again seeking money damages in the amount of their funds which had been wrongfully taken or recouped; all stipulations in the District Court were refiled; and petitioners and respondent each filed motions for summary judgment. The court below found no genuine issue as to any material fact; and, concluding that it had no subject matter jurisdiction, it dismissed the petition. Despite the extraordinary circumstances of the case arising out of the Fifth Circuit's reliance on an assumption that there

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[8] 5 U.S.C. §§701-706. The court below relied on *Califano* v. *Sanders,* 430 U.S. 99.

[9] The Fifth Circuit relied on its decision in *John T. MacDonald Foundation* v. *Califano,* 571 F.2d 328 (5th Cir.) cert. denied 439 U.S. 893. This *MacDonald* decision was the culmination of a trilogy. That court in 534 F2d 633 held that there was jurisdiction under the Administrative Procedure Act; on rehearing, 554 F.2d 714, it held that there was not, but that there was subject matter jurisdiction under 28 U.S.C. § 1331(a). After rehearing *en banc,* 571 F.2d 328, the court held that there was no subject matter jurisdiction under either statute—because of 42 U.S.C. 405(h) as interpreted in *Weinberger* v. *Salfi,* 422 U.S. 749, and incorporated into 42 U.S.C. § 1395ii—and transferred the case to the Court of Claims because that court had held that there was jurisdiction. *Whitecliff, Inc.* v. *U.S.,* 536 F.2d 347 (Ct. Cl. 1976), cert. denied 430 U.S. 969.

[10] As revealed in its later decision, the supposed "availability of Court of Claims jurisdiction," persuaded the Fifth Circuit to avoid a decision of whether mandamus jurisdiction might be available, even though § 1331 jurisdiction might not be. *Pushkin* v. *Califano,* 600 F.2d 486, 489 and n. 5 (1979): "Since we find that the claim of error . . . can be reviewed in the Court of Claims, we need not express an opinion on the amenability of this issue to resolution by mandamus."

was Court of Claims jurisdiction to hear and decide the constitutional claim of Alabama Hospitals, the court below held that it was free to evaluate its own jurisdiction at anytime.

The court below conceded that the result of its decision was a holding that a statute of Congress precluded *all* judicial review in *all* federal courts (including the court below), of an asserted denial of procedural due process—an assertion proved to the satisfaction of a respected district judge, who ordered judicial relief, and an assertion which the Fifth Circuit held to be of such substance as to require a transfer to the court below.[11]

> "Concededly, the import of today's decision and that of the Fifth Circuit decision earlier in this litigation is that the providers are unable, in their own stead, to challenge either the adverse coverage determinations or the constitutionality of the recoupment procedures. That result, as the text discusses, is itself constitutional and is mandated by the Medicare statutes as they read during the relevant periods. If there is inequity or unfairness in this result, it is for the Congress, and not this court, to remedy." (Ms. p. 15, n. 10; Appendix A, A-18.)

Notwithstanding, the court below also denied petitioners' motion to alter or amend its judgment—in the manifest interest

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[11] As the Fifth Circuit elaborated in *Bussey* v. *Harris*, 611 F.2d 1001, 1005 (1980):

> "Because review of any substantial constitutional question in the instant case in fact is available in the Court of Claims, we do not decide whether Congress has, or could constitutionally have, precluded judicial review of a substantial constitutional claim, an issue that the Supreme Court has not resolved. *Pushkin* v. *Califano*, 600 F.2d at 492; *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d at 331 n.5, 332. *We instead assess whether appellees have raised substantial constitutional issues to determine whether to transfer this action to the Court of Claims or to dismiss it for lack of subject matter jurisdiction.*" (Emphasis supplied.)

of justice—to transfer the case either to the Fifth Circuit or to the District Court so that those courts could decide the grave constitutional question of whether Congress may preclude all federal courts from a judicial determination of whether the money of Alabama Hospitals may be taken without due process of law.

The explanation of the conclusion of the court below that it had no subject matter jurisdiction to hear and decide this serious constitutional challenge is as follows. Its decision in *Whitecliff, Inc.* v. *U.S.*, 536 F.2d 347, cert. denied 430 U.S.969, ("*Whitecliff*") stands for the proposition that the Court of Claims reviews administrative adjudications under the Medicare statute only where all other review is unavailable and where " 'absolute finality' would therefore be accorded to adjudications by the intermediaries."[12] If the pre-1973 Medicare statute " 'provides for review' of adverse coverage determinations," then the Court of Claims has no subject matter jurisdiction.[13] The court below reasoned that although the pre-1973 statute[14] denied Alabama Hospitals, as providers, any right to contest administratively or in the courts an initial adverse coverage decision, the statute did not prohibit the hospitals from proceeding against their innumerable former patients. Thus, the rationale below continued, the patients, and not the hospitals, bore the final loss caused by adverse coverage determinations; and the provider hospitals possessed no "true economic interest."[15] For this reason the court below held that its earlier decision in *Whitecliff* did not provide subject matter jurisdiction; and it dismissed the action for lack of it.

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[12] Ms., p. 9; Appendix A, p. A-11.

[13] Ms. p. 10, Appendix A, p. A-12.

[14] It had been stipulated that only the pre-1973 statute was relevant to these proceedings.

[15] Ms. p. 16, Appendix A-20. This holding that the providers had no "true economic interest," and thus no constitutionally protected

All relevant facts are stipulated.[16] Alabama Hospitals provided medical services during the period 1967-1972 for which they sought reimbursement from HHS. Blue Cross, after fiscal review and audit, determined that there had been an overpayment to those hospitals, in the amounts specified in the stipulation, because of over utilization of hospital services by patients in these hospitals. Patient files were reviewed by registered nurse employees of the fiscal intermediary and its medical con-

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property interest, as will be elaborated, squarely conflicts with the holding of the Fifth Circuit in *Mt Sinai Hospital* v. *Weinberger,* 517 F.2d 329 and 522 F.2d 179 (1975):

> "The parties primarily concerned with coverage determinations are HEW and the beneficiary. In theory the provider's interest is slight because the coverage determination merely has the effect of resolving who shall pay it for the services, Medicare or the individual. * * * As a practical matter, however, the provider is greatly concerned about who its debtor is. The alternative debtors are the government and a private individual who may be hard to find, harder to collect from, and impossible to placate if collection from him is necessary."

On rehearing in *Mt. Sinai,* 522 F.2d 179, 180, the Court again found constitutionally significant "the exposure of the provider to the possibility of bearing the loss . . ."

The holding below conflicts with the holding of the District Court in the instant case:

> "[O]btaining payment from the defendants rather than having to try to collect from numerous individuals of uncertain location and financial condition, many of whom may in fact be dead, is a substantial interest."

The holding conflicts with the holding of the Fifth Circuit in this case, *sub silentio,* that a substantial claim of constitutional deprivation required transfer to the court below for decision there.

And, the holding below conflicts, indeed, with the agreement and concession of the United States in the identical circumstances of *Mt. Sinai Hospital* v. *Mathews,* 425 F. Supp. 5, 10 (S.D. Fla 1976), quoted *infra,* n. 19.

[16] The stipulation is appended as Appendix E.

sultants; and the fiscal intermediary made a unilateral determination of whether all or any part of a hospital stay was or was not reasonable and necessary. To the extent that the fiscal intermediary determined that payments, as reimbursement for hospital care, had been made to these hospitals for services thus determined to be unnecessary, the fiscal intermediary sought repayment of those amounts. As an alternative to repayment by these hospitals, HHS asserted the right of recoupment against future requests for reimbursement for future services. The total sum thus taken from Alabama Hospitals by this method was stipulated to be $656,571.18.

In the conduct of fiscal review of Alabama Hospitals and audit procedures, HHS took the position that it could decide unilaterally without evidentiary hearing or review—either before or after determining that these hospitals had received medicare reimbursement to which they were not entitled. HHS only furnished to these hospitals the names of those patients who were deemed to have been unnecessarily treated or to have been the recipients of noncovered services.[17]

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[17] It was stipulated (Appendix E.):

> "Notwithstanding requests by these class members for hearing or review of these adverse determinations of defendants, the determinations were made unilaterally by defendants; defendants did not grant hearings or review procedures in connection with or after adverse determinations of over payment to these class members, and the assertion of the right to recoupment or offset from or against them. Defendants took the position that such unilateral determinations of over payments, without opportunity for hearing or review, were contemplated under and by the Medicare Act; and, moreover, that there was no provision in the Medicare Act or regulations promulgated thereunder for hearing or review prior to or after administrative determination of over payment and of a right to recoupment and offset."

REASONS FOR GRANTING THE WRIT

HHS took approximately $657,000 from Alabama Hospitals after a unilateral, ex parte determination of over payment for non-covered services. HHS' procedure violated basic principles of due process which require an evidentiary hearing *at some point* in administrative proceedings—a hearing which is fair, before an impartial tribunal, with opportunity to present evidence, to know the claims of the opposing party and to meet them. Due process secures a right to such a hearing, either before or after a final determination of non-covered services, and a right to subsequent judicial review. *Opp Cotton Mills* v. *Administrator,* 312 U.S. 126, 152-153; *Morgan* v. *United States,* 304 U.S. 1, 18-19; *Goldberg* v. *Kelly,* 397 U.S. 254, 267-8; *Mathews* v. *Eldridge,* 424 U.S. 319, 323-333; *Parratt* v. *Taylor,* ____ U.S. ____, 49 U.S.L.W. 4509 (1981).[18]

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[18] In recent years this Court's decisions have required hearings in varied contexts:—*Memphis Light etc. Div.* v. *Craft,* 436 U.S. 1, (termination of utility service); *Goss* v. *Lopez,* 419 U.S. 565 (suspension of student from public high school); *North Georgia Finishing* v. *Di-Chem, Inc.,* 419 U.S. 601 (garnishment of bank account); *Arnett* v. *Kennedy,* 416 U.S. 134 (discharge from public office); *Wolff* v. *McDonnell,* 418 U.S. 539 (prison disciplinary proceedings); *Bell* v. *Burson,* 402 U.S. 535 (suspension of a driver's license); and *Wisconsin* v. *Constantineau,* 400 U.S. 433 (government labeling of a person as an "excessive drinker.")

This Court quite recently summarized its requirements, *Parratt* v. *Taylor,* ____ U.S. ____, 49 U.S.L.W. 4509, 4512:

> "Our past cases mandate that some kind of hearing is required at some time before a State finally deprives a person of his property interests. The fundamental requirement of due process is the opportunity to be heard and it is an 'opportunity which must be granted at a meaningful time and in a meaningful manner.' (Cit.)"

This Court on October 13, 1981 noted probable jurisdiction of the appeal from *Schweiker* v. *McClure,* 503 F. Supp. 409 (N. D. Cal. 1980).[19] The circumstances which caused the *McClure* court to invalidate, on due process grounds, the Part B hearing procedures of the Medicare Act pale by comparison with the *no* hearing—*no* review procedure inflicted on Alabama Hospitals. That court invalidated those procedures because those claims were determined "by [insurance] carrier appointees whose impartiality is subject to doubt." 503 F. Supp. at 418.[20]

The District Court correctly held that Alabama Hospitals were denied due process when their funds were taken or recouped without any evidentiary hearing or review at any point in the administrative proceedings; and it also correctly held that:

> "[O]btaining payment from the defendants rather than having to try to collect from numerous individuals of uncertain location and financial condition, many of whom may in fact be dead, is a substantial interest."[21]

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[19] No. 81-212, 50 U.S.L.W. 3278.

[20] It is noteworthy that the district court in *McClure* found subject matter jurisdiction to review constitutional claims of deprivation of due process even though it held that there was no subject matter jurisdiction "to review the merits of the decisions denying [the] benefits claims." 503 F. Supp. at 412. This is the precise jurisdictional path unsuccessfully urged by Alabama Hospitals and rejected by the Fifth Circuit in the case at bar:

> "The plaintiffs argue that *MacDonald* can be distinguished because § 405(h)'s bar to jurisdiction applies only to appeals from findings and decisions of the Secretary, and here the plaintiffs sued because HEW held no hearing. But this court decided (Cit.) that the lack of an 'administrative hearing or decision . . . does not serve as a relevant distinction . . . .' (Cit.)" 587 F.2d 762, 763.

[21] As already noted, the District Court's holding that there is a constitutionally protected property interest accords with the Fifth

The Fifth Circuit did not disagree with the District Court's decision. It held, however, that the District Court had no jurisdiction to secure to Alabama Hospitals their constitutional guaranty of procedural due process; and that there is no judicial remedy in any federal court for these persons whose property has been taken without a semblance of procedural due process, and by patently unconstitutional means. It did so on the basis of its earlier decisions in *John T. MacDonald Foundation,* 571 F.2d 328 (5th Cir.), cert. denied, 439 U.S. 893; and *American Association of Councils* v. *Califano,* 575 F.2d 1367, cert. denied 439 U.S. 1114. Its reasons were (587 F.2d 762, 763):

> "*MacDonald* involved a challenge by a provider of Medicare services to HEW's method of determining reimbursable cost. On the basis of *Weinberger* v. *Salfi,* 422 U.S. 749, . . . this court concluded that the incorporation of 42 U.S.C. § 405(h) into the Medicare Act through 42 U.S.C. § 1395ii, eliminated subject matter jurisdiction under 28 U.S.C. § 1331(a) to review the validity of HEW's reimbursement procedures. That decision controls this case."

The Fifth Circuit recognized the enormous impact of its decisions that a statute of Congress precluded all judicial review in the federal courts of an alleged denial of procedural due process. Because the Court of Claims in *Whitecliff* had held that the same Congressional statute did *not* preclude its jurisdiction to consider and decide such a constitutional claim, the Fifth Cir-

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Circuit's holding in *Mt. Sinai Hospital* v. *Weinberger,* 517 F.2d 329, 335 (5th Cir. 1975) quoted n. 15, *supra.*

The District Court's holding also accords with HHS's own concession in *Mt. Sinai Hospital* v. *Mathews,* 425 F. Supp. 5, 10:

> "HEW agrees that the continued receipt [by providers] of Medicare payments constitutes 'property' within the meaning of due process, but asserts that the administrative procedures followed in this case were adequate under the Constitution and the relevant case law."

cuit *en banc* in *MacDonald*—as in the case at bar—sought to avoid the serious constitutional implications by transferring the case there under 28 U.S.C. § 1406(c):

> "Happily, we need resolve neither Congress' intent to preclude review of constitutional claims nor the constitutionality of a statute so construed. We would face these issues only if *all* avenues of review were precluded." (571 F.2d at 332; emphasis by the court.)

Moreover, the Fifth Circuit has continued to assume that it may safely avoid this serious constitutional decision because, "[g]iven the availability of . . . Court of Claims jurisdiction," judicial review of constitutional questions such as those at bar "was not . . . totally barred." *Pushkin* v. *Califano,* 600 F.2d 486, 490 (5th Cir. 1979):

> "Because Court of Claims jurisdiction is available, total preclusion of judicial review does not result from the congressional decision to restrict district court jurisdiction."

The Fifth Circuit reiterated its position in *Bussey* v. *Harris,* 611 F.2d 1001, 1005 (1980), and explained as well its procedure of making a threshold determination of whether the constitutional question was "substantial" in order to determine "whether to transfer [the] action to the Court of Claims or to dismiss it for lack of subject matter jurisdiction."

Now, however, the Court of Claims has transformed this litigation into a manifestly unjust travesty which combines the most egregious and bizarre misfortunes of the fictional *Jarndyce* v. *Jarndyce*[22], and the Flying Dutchman, who was bound to sail the seas forever without coming to port. It has held that it does *not* have subject matter jurisdiction. And the basis for its holding is contrary to the holding of the District Court at bar;

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[22] Dickens, *Bleak House.*

contrary to the holding of the Fifth Circuit in *Mt. Sinai, supra.;* and contrary to the holding of the Fifth Circuit at bar that Alabama Hospitals have raised a substantial constitutional question. All stand for the proposition that the identical property interest asserted by Alabama Hospitals is a constitutionally protected one.[23] All of those courts rejected the very reason for the Court of Claims declination of subject matter jurisdiction, namely, that the provider hospitals had no constitutionally protected property interest because the patients had a right to an administrative hearing and judicial review, and because the provider hospitals could sue the patients—patients, as these courts concluded, who might be dead or long gone.

Even the United States has acquiesced in earlier holdings that provider hospitals *did* have a constitutionally protected property interest in circumstances identical to those at bar, *Mt. Sinai Hospital* v. *Mathews,* 425 F. Supp. 5, 10, *supra.* And even the court below itself realized that the plain "import" of its decision "is that the providers are unable, in their own stead, to challenge either the adverse coverage determinations or the constitutionality of the recoupment procedures." (Ms. p. 15, n.10)

The court below may not cavalierly dismiss the constitutional deprivation inflicted on Alabama Hospitals as a mere "inequity or unfairness . . . for the Congress . . . to remedy." (*Ibid.*) The question of non-reviewable executive decisions—as pervasive and intrusive as those under the Medicare Act—even decisions made without a semblance of procedural due process—cannot be so lightly avoided. The impact of the judgment below is grave. The issues are momentous and call urgently for the consideration and determination of this Court. The decision below, if it stands, will severely undermine transcendant guaranties of

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[23] See n. 15, *supra.*

fairness[24] and our traditional system of checks and balances. Moreover, the decision below—which precludes all federal jurisdiction to hear and decide due process claims—conflicts, as noted, with holdings of the Fifth Circuit in this case and others that Alabama Hospitals have a constitutionally protected property interest in the funds which were taken or recouped.[25]

The court below has now held that Congress, by §§ 405(h) and 1395ii, precluded all judicial review of administrative denials of procedural due process to Alabama Hospitals. It has thus presented this Court with a constitutional question of the first magnitude—" 'one that has arisen but rarely and tangentially in our constitutional history, i.e. whether the Congress can close the federal courts entirely to constitutional challenges directed against federal statutes or action.' "[26]

The decision below answers this grave question in a manner which squarely conflicts with this Corut's holding in *Califano* v. *Sanders,* 430 U.S. 99, 109:

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[24] Justice Frankfurter has eloquently described "due process" as a "profound attitude of fairness between man and man, and more particularly between the individual and government. * * * Due process is not a mechanical instrument. It is not a yardstick. It is a process. It is a delicate process of adjustment inescapably involving the exercise of judgment by those whom the Constitution entrusted with the unfolding of the process." *Joint Anti-Fascist Refugee Com.* v. *McGrath,* 341 U.S. 123, 162-163.

[25] A conflict between a decision of the Court of Claims and a contrary holding of a United States Court of Appeals is a well established basis for this Court's exercise of certiorari jurisdiction. *U.S.* v. *Hopkins,* 427 U.S. 123, 124; *Commissioner* v. *Idaho Power Co.,* 418 U.S. 1, 4; *Commissioner* v. *National Alfalfa Dehydrating Co.,* 417 U.S. 134, 141-142; *Waterman S.S. Corp.* v. *U.S.,* 381 U.S. 252, 258.

[26] *Cervoni* v. *Secretary of Health, Ed. and Welfare,* 581 F.2d 1010, 1016-17 (1st Cir. 1978).

> "Thus those cases [Salfi and Mathews v. Eldridge, 424 U.S. 319] merely adhered to the well established principle that when constitutional questions are in issue, the availability of judicial review is presumed, and we will not read a statutory scheme to take the 'extraordinary' step of foreclosing jurisdiction unless Congress' intent to do so is manifested by 'clear and convincing' evidence." [Citing *Salfi* and *Johnson* v. *Robison,* 415 U.S. 361, 366-367.]

The decision below conflicts also with this Court's holding in *Johnson* v. *Robison,* 415 U.S. 361, 366-367:

> "We consider first appellants' contention that § 211(a) bars federal courts from deciding the constitutionalty of veterans' benefits legislation. Such a construction would, of course, raise serious questions concerning the constitutionality of § 211(a), and in such case it is a cardinal principle that this Court will first ascertain whether a construction of the statute is fairly possible by which the [constitutional] question[s] may be avoided."

One of the precedents which this Court cited in *Johnson* v. *Robison* to exemplify the gravity of such preclusion is the classic concurrence of Justice Brandeis in *St. Joseph Stock Yards* v. *U.S.,* 298 U.S. 38, 84:

> "The supremacy of law demands that there shall be opportunity to have some court decide whether an erroneous rule of law was applied; and whether the proceeding in which facts were adjudicated was conducted regularly. To that extent, the person asserting a right, whatever its source, should be entitled to the independent judgment of a court on the ultimate question of constitutionality."

Surely this is not the time in our history when it would serve the values enshrined in our Constitution for this Court to let stand a decision by the Court of Claims or any Court of Appeals of the United States that Congress may preclude all federal

courts from deciding whether an enormous and pervasive federal department may take the property of our citizens without affording due process of law.

Finally, as already argued, the decision below is manifestly incorrect in holding that Alabama Hospitals have no constitutionally protected property interest in the monies taken and recouped; and in its concomitant holding that a federal statute wholly precludes the court below and all other federal courts from deciding on the facts stipulated in this case that HHS, through its secretary and its fiscal intermediary, Blue Cross-Blue Shield, had denied Alabama Hospitals procedural due process by taking from them $657,000 of their money without the semblance of a hearing before or after the final decision to take. The implications of that erroneous decision—that Congress had thus assaulted our constitutional system—call for the judgment of this Court. The labyrinthine trail of this litigation insults, moreover, established precepts of legislative and judicial fairness. The time for this Court's review is at hand.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this petition for writ of certiorari should be granted.

Respectfully submitted,

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Appendix

APPENDIX A

IN THE UNITED STATES COURT OF CLAIMS

No. 465—79C

(Decided June 17, 1981)

Alabama Hospital Association, et al.

v.

The United States

M. Roland Nachman, Jr., attorney of record, for plaintiffs. *Steiner, Crum & Baker* and *John P. Oliver, II*, of counsel.

Elizabeth Langer, with whom was *Assistant Attorney General Alice Daniel*, for defendant.

Before KASHIWA, BENNETT, and SMITH, *Judges*.

ON PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DEFENDANT'S CROSS MOTION FOR JUDGMENT ON THE PLEADINGS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

KASHIWA, *Judge*, delivered the opinion of the court:

This case is before the court on plaintiffs' motion for summary judgment and defendant's alternative cross motion for summary judgment or motion for judgment on the pleadings. There is no genuine issue as to any material fact. After hearing oral argument and fully considering the parties' submissions, we hold in defendant's favor.

This case is the most recent in a number of suits concerning Medicare. The present case was first filed as a class action in the district court but was transferred here pursuant to 28 U.S.C. § 1406(c) (1976) after the circuit court of appeals vacated the unreported district court decision for a lack of subject matter jurisdiction. *Alabama Hospital Association* v. *Califano,* 587 F. 2d 762 (5th Cir.), *cert. denied,* 444 U.S. 826 (1979). In the district court, the parties had stipulated that the action was "properly maintainable and may proceed as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure * * *." After transfer, the plaintiffs[1] originally sought to continue the class action here pursuant to the stipulation; while the defendant contended the somewhat different considerations applicable to such actions here rendered the stiulation of little value.[2] Fortunately, upon the court's suggestion at oral argument, counsel for the plaintiffs agreed to pursue this case as a

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[1] The district court characterized the plaintiffs in the class action as follows:

"Plaintiffs are the Alabama Hospital Association, an organization comprised of approximately 140 hospitals in the State of Alabama, and the Tallapoosa County Hospital Board, Inc., which operates a hospital in Dadeville, Alabama. Plaintiff Tallapoosa County Hospital Board sues on its own behalf, and each plaintiff sues on behalf of all private non-profit, private proprietary, and non-federal governmental hospitals located in Alabama with the exception of the Hospital Association of Conecuh County."

The petition filed here after transfer named as plaintiffs the Alabama Hospital Association, the Tallapoosa County Hospital Board, Inc., the Chilton County Hospital Board, and the Maco County Hospital Association. The Tallapoosa County Board, the Chilton County Board, and the Macon County Association all appear to be members of the Alabama Hospital Association.

[2] *See Quinault Allottee Ass'n* v. *United States,* 197 Ct. Cl. 134, 453 F. 2d 1272 (1972); *Crone* v. *United States,* 210 Ct. Cl. 499, 538 F. 2d 875, *modified,* 210 Ct. Cl. 748 (1976).

joint action under Court of Claims Rule 63(a). As defendant concurred, we proceed on that basis.[3]

Federal Health Insurance for the Aged, popularly known as Medicare, was enacted by Congress in Title I of the Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 101-122, 79 Stat, 286 (1965), as Subchapter XVIII of the Social Security Act. The 1965 legislation, as amended, presently is codified at 42 U.S.C. §§ 1395-1395rr (1976 and Supp. III 1979). Subsequent statutory references are to the 1970 United States Code except as noted.

Medicare consists of two basic parts. Parts A (42 U.S.C. §§ 1395c—1395i-1) provides insurance for hospital and related post-hospital services. Part B (42 U.S.C. §§ 1395j-1395w) provides insurance for supplemental medical services apart from hospitalization, such as those rendered by physicians. This case arises under Part A.

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[3] Thus, the joint plaintiffs in this action are the members of the Alabama Hospital Association contained in plaintiffs' Exhibit X: John A. Andrew Memorial Hospital, Baptist Medical Center Montclair, Baptist Memorial Hospital, Parkway Medical Center Hospital, Blount Memorial Hospital, Chambers County Hospital, Colbert County Hospital, Columbia General Hospital, Community Hospital, Inc., Courtland Community Hospital, Druid City Hospital, East Tallapoosa Hospital, Fayette County Hospital, Florala Memorial Hospital, Inc., Greene County Hospital, Henry County Hospital, Lister Hill Hospital, Huntsville Hospital, Lamar County General Hospital, Macon County Hospital, Mizell Memorial Hospital, Mobile General Hospital, Northeast Alabama Regional Medical Center, North Jackson Hospital, Perry County Hospital, Pineview Hospital, Randolph County Hospital, St. Jude's Catholic Hospital, Shoals Hospital, Inc., South Baldwin Hospital, Stringfellow Memorial Hospital, St. Martin de Porres, Chilton County Hospital, and Athens-Limestone Hospital. The Alabama Hospital Association cannot be a party plaintiff as it does not operate a hospital and thus has no claim for money damages against the United States. *See United States* v. *King*, 395 U.S. 1, 3 (1969).

Under Part A, the cost of essential hospital services for persons aged 65 and older is paid from a trust fund financed by wage taxes on employees and self-employers. The trust fund makes payments for the benefit of elderly individuals directly to the institutions offering the services. However, before an institution can receive payments, certain requirements, such as accreditation, must be met. See 42 U.S.C. §§ 1395(a), 1395x(u), and 1395bb. Moreover, these institutions commonly known as providers, must enter agreements with the Secretary of Health, Education and Welfare (HEW). Those agreements must meet the requirements of 42 U.S.C. §§ 1395cc(a) and 1395f(a). Payment for services is based on the reasonable cost of such services, 42 U.S.C. §1395f(b), as determined pursuant to 42 U.S.C. § 1395x(v) and implementing regulations.

Private, non-governmental entities handle the routine administration of both Part A and Part B. These entities are termed "fiscal intermediaries" under Part A and "carriers" under Part B. Usually, these entities are health and accident insurance companies such as Blue Cross organization. The Part A intermediaries are nominated by a provider or group of providers and themselves enter contracts with HEW. These intermediaries serve as HEW's agent for many functions, such as hospital audits, information dissemination, and fund disbursement.

In making Part A disbursements, the fiscal intermediaries must resolve two important and distinct questions: (1) whether the particular services provided to a beneficiary are covered under 42 U.S.C. § 1395d and not excluded by 42 U.S.C. § 1395y, *i.e., coverage* determinations; and (2) whether the amount paid for the services is the reasonable cost under 42 U.S.C. § 1395x(v), *i.e., reasonable cost* determinations. The two determinations are made under different procedures, which we discuss more fully below.

In 1972 the fiscal intermediary for provider hospitals in Alabama reviewed certain earlier coverage determinations

favorable to the providers. The review assessed whether the services which had been rendered were medically "reasonable and necessary" as required by 42 U.S.C. § 1395y(a)(1). The provider hospitals had previously been reimbursed by Medicare for the services. The investigations consisted of a bi-level review in which patient files were first examined by registered nurses employed by the fiscal intermediary. Those files which suggested medically unnecessary services had been performed were then reexamined by consulting physicians also employed by the intermediary. The intermediary made such coverage redetermination only after a consulting physician concurred with the preliminary finding of the registered nurse.

After the review had been completed, the hospitals were informed by letter of any overpayment resulting from adverse coverage redeterminations, the names of beneficiaries involved, the number of days of service disallowed, and the specific amount of the overpayment. The letter also requested repayment. As a result of such letters, the majority of the provider hospitals "voluntarily" repaid the amounts requested. The remaining hospitals had these overpayments recouped from later unrelated Medicare payments. The correctness of the later Medicare payments is not presently in dispute.

These Medicare providers seek money damages in the amount of monies repaid or recouped, alleging as all plaintiffs in this court must, jurisdiction under the Tucker Act, 28 U.S.C. § 1491 (1976).[4] Plaintiffs exact theory of jurisdiction, however, is somewhat confused. At one point, plaintiffs assert:

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[4] 28 U.S.C. § 1491 (1976) provides in relevant part:

"The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort."

> This is not a case where the issue for determination is whether or not certain provider hospitals were entitled under the Medicare Act to reimbursement for hospital services. The issue is whether the United States, through HEW, may take from these Alabama hospitals $657,000 of funds already paid to them and already in their coffers, without affording them a hearing which satisfies the constitutional requirements of due process of law.

Plaintiffs' repeated citation of *Whitecliff, Inc.* v. *United States,* 210 Ct. Cl. 53, 536 F. 2d 347 (1976), *cert. denied,* 430 U.S. 969 (1977), and similar cases, which hold that Medicare cases arising prior to 1973 are within our Tucker Act jurisdiction as claims founded on the Medicare contracts and statute, *id.* at 58, 536 F. 2d at 351, suggests plaintiffs nevertheless assert this basis as well. Moreover, plaintiffs' citation of *Kirkendall* v. *United States,* 90 Ct. Cl. 606, 31 F. Supp. 766 (1940), *United States* v. *State Bank,* 96 U. S. 30 (1877), and similar cases, offers the further possibility that plaintiffs are alleging contract-implied-in-fact jurisdiction.

This apparent confusion as to the jurisdictional basis for suit, as well as the related assertion by plaintiffs that this court should do no more than apply the vacated district court decision, causes considerable attention to be directed towards a non-issue, whether this court has jurisdiction to award money damages if the Due Process Clause of the Fifth Amendment has been violated. It is well settled, as the defendant correctly argues, that we have no jurisdiction over a claim founded solely on that provision. The Due Process Clause simply cannot be read to mandate money damages be paid, as *United States* v. *Testan,* 424 U. S. 392, 400 (1976), requires. *E.g., Gordon* v. *United States,* Ct. Cl. No. 310-79T (slip op. of May 6, 1981, at p. 2 n.2); *Carruth* v. *United States,* 224 Ct. Cl. ____, ____, 627 F. 2d 1068, 1081 (1980); *Vlahakis* v. *United States,* 215 Ct. Cl. 1018, 1019 (1978). It does not follow, however, that this petition must be dismissed as beyond our Tucker Act jurisdiction. It is

equally well settled that where a claim appears to be within our jurisdictional statute, as for example one founded on statute or contract, that claim is not removed from our jurisdiction merely because a plaintiff must make a constitutional argument to prevail. *Gentry* v. *United States,* 212 Ct. Cl. 1, 5-8, 546 F. 2d 343, 345-346 (1976). Thus, in *Overlook Nursing Home, Inc.* v. *United States,* 214 Ct. Cl. 60, 556 F. 2d 500 (1977), and *Ulman* v. *United States,* 214 Ct. Cl. 308, 558 F. 2d 1 (1977), we passed on due process claims in the context of the Medicare statute. On this issue, the present controversy is no different from *Overlook* and *Ulman.* When this petition is reduced to its essentials, and despite plaintiffs' contrary assertions, these are at least claims founded on the Medicare contracts and statute. *See, e.g., Pasadena Hospital Association, Ltd.* v. *United States,* 223 Ct. Cl. ____, ____, 618 F. 2d 728, 729-730 (1980); *Overlook, supra; Whitecliff, supra.* These claims are within the literal breadth of the Tucker Act.

Once the literal requirements of the Tucker Act are satisfied, plaintiffs contend, this court should apply the rationale of the district court on all subsequent issues in this suit. The district court concluded that this suit was not barred under the statutory scheme and further concluded that due process required a hearing on the compelled repayments. The district court then required the defendant to hold an appropriate hearing and awarded damages if the defendant failed to do so. Plaintiffs' theory appears to be that a failure of subject matter jurisdiction is a sort of minor procedural defect which prevents immediate enforcement of a decision but leaves the underlying reasoning intact.

It is well settled, however, that a ruling on the merits in a suit thereafter dismissed for lack of jurisdiction is not conclusive in a subsequent suit on the same claim. *E.g., Faith Hospital Association* v. *United States,* 218 Ct. Cl. 255, 263, 585 F. 2d 474, 478 (1978) (*Faith I*); *Alabama Rural Fire Insurance Co.* v. *United States,* 215 Ct. Cl. 442, 452-453 n.10, 572 F. 2d 727, 732 n. 10 (1978). *See also International Philanthropic Hospital*

Foundation v. *United States,* 223 Ct. Cl. ____, 621 F. 2d 402 (1980). Far from being a minor procedural matter, a lack of subject matter jurisdiction goes to the very power of a court to hear a controversy; and thus, any "decision" by a court lacking subject matter jurisdiction is a nullity, *void ab initio.* Although a court which later properly entertains the controversy may regard the earlier discussion helpful, that earlier decision can be accorded no weight either as precedent or as law of the case. *Duncan* v. *United States,* 220 Ct. Cl. 1, 597 F. 2d 1337 (1979), *vacated and remanded,* 446 U. S. 903 (1980), is not to the contrary. Even assuming *arguendo* that case had not been vacated, its result is easily distinguishable. In *Duncan,* plaintiffs had filed suit in district court seeking declaratory, injunctive, and monetary relief. The district court ruled on plaintiffs' claims insofar as they pertained to the declaratory and injunctive relief sought and transferred the remainder of the suit to this court. In *Duncan,* unlike the case at bar, the district court clearly had subject matter jurisdiction over the equitable claims. Therefore, collateral estoppel prevented relitigation of the issues determined in the district court. Plaintiffs, therefore, can take no comfort from *Duncan;* and the other cases plaintiffs cite are likewise distinguishable. It follows, of course, that we must determine for ourselves whether the jurisdiction provided under the Tucker Act has been limited as to Medicare Part A coverage determinations.

Defendant argues that the incorporation of 42 U.S.C. § 405(h) into the Medicare statutes via 42 U.S.C. § 1395ii[3] supplies that limitation. Section 405(h), Title 42 of the United States Code, provides:

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[3] 42 U.S.C. § 1395ii provides:

"The provisions of sections 406, 408, and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k) [and] (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter."

(h) *Finality of Secretary's decison.*

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

The defendant's argument is straightforward: 42 U.S.C. § 405(h), as interpreted in *Weinberger* v. *Salfi*, 422 U. S. 749, 756-763 (1975), prohibits judicial review of Social Security Act determinations (including those under Medicare) other than as provided in the statutes.[6] As the only applicable provisions, 42 U.S.C. §§ 405(g) and 1395ff, do not entitle providers to a hearing or judicial review of adverse coverage determinations such as these, it follows, says the defendant, that this action must be dismissed.[7]

To be sure, the defendant's contention is hardly novel. We have previously rejected such an argument as to suits concerning pre-1973 reasonable cost disputes under Part A (*e.g.*, *Whitecliff, supra*) and as to post-1973 reasonable cost disputes

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[6] It has been settled since *Goldstein* v. *United States*, 201 Ct. Cl. 888, 889, *cert. denied*, 414 U. S. 974 (1973), and *Burton* v. *United States*, 205 Ct. Cl. 846, 846 (1974), that 42 U.S.C. § 405(h) has applications to actions in this court despite a dearth of literal language to that effect.

[7] For simplicity's sake, we refer collectively to the methods of review specified in 42 U.S.C. §§ 405(g), 405(h), 1395ff(b), and 1395ff(c) as the legislative scheme. That scheme was amended in 1972 by sections 243 and 299O of the Social Security Amendments Act of 1972, Pub. L. No. 92-603, 86 Stat. 1329, and by section 3 of the Act of October 26, 1974, Pub. L. No. 93-484, 88 Stat. 1459. As these amendments apply only to cost periods after June 30, 1973, the parties agree these amendments are inapplicable to the present suit.

under Part B (*Erika, Inc.* v. *United States*, 225 Ct. Cl. ____, 634 F. 2d 580 (1980), *cert. granted*, ____ U. S. ____ (May 18, 1981)), to the extent that providers in those circumstances allege a violation of constitutional, statutory, or regulatory provisions. We have not, however, had occasion to pass on this issue as it relates to *coverage* determinations under Part A for pre-1973 periods.

Whitecliff, supra, has been the touchstone on the relationship between 42 U.S.C. § 405(h) (as explained in *Salfi*) and the Medicare provisions. In *Whitecliff,* we wrote:

> We decline the invitation to extend *Salfi's* reading of Section 405(h) to this Medicare case. The social security provisions with which the Supreme Court dealt in *Salfi* authorize appeals of all decisions made after hearings, without limitation as to issues; the practical effect of the *Salfi* decision was simply the enforcement of the Section 405(g) procedures and prerequisites to judicial review. *See also Mathews* v. *Eldridge*, 424 U.S. 319, 326-32 (1976). By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers. To import into the Medicare program the *Salfi* preclusion of judicial review (except as expressly authorized) *would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA*. Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review.[7] *We cannot assume that the Supreme*

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[7] *See generally Johnson* v. *Robinson*, 415 U.S. 361, 366-68, 373-74 (1974); *Barlow* v. *Collins*, 397 U.S. 159, 166-67 (1970); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F. 2d 663, 667-68 (2d Cir. 1973); Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 Geo. L.J. 107, 126-29 (1974). In *Salfi* the Supreme Court distinguished *Johnson* v. *Robison, supra,* a case in which the Court held that a

Court would extend the Salfi interpretation of Section 405(h) to Medicare cases, where the consequences would be so dramatically different, and therefore we adhere to the pre-Salfi view of judicial review of Medicare provider disputes: Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions. In this court, 28 U.S.C. § 1491 (the Tucker Act) is the pertinent jurisdictional provision both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers. *Cf. United States* v. *Testan,* 424 U.S. 392 (1976). [Emphasis supplied; other footnotes omitted.]

Thus, *Whitecliff* stands squarely for the proposition that *Salfi* is inapplicable to Medicare situations where "all review" is prevented and where "absolute finality" would therefore be accorded to adjudications by the intermediaries. The rule formulated by the *Whitecliff* court (and the rule which we are bound to apply, *see Dravo Corp.* v. *United States,* 219 Ct. Cl. 416, 419, 594 F. 2d 842, 843 (1979)), is that:

> * * * Where the Medicare statute provides for review, providers and courts must follow the specified procedures

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statute similar to 42 U.S.C. § 405(h) did not preclude review of the question raised, in part on the ground that review of a constitutional challenge to the statute would have been cut off if the interpretation contended for by the Government in *Johnson* had prevailed, while no constitutional challenges would be denied review under the Social Security Act. *See* 422 U.S. at 762.210 Ct. Cl. at 57-58, 536 F. 2d at 350-351.

> and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable. * * * [210 Ct. Cl. at 58, 536 F. 2d at 351.]

Whitecliff, of course, concluded that no review was provided in the statute of Part A reasonable cost determinations for pre-1973 periods and that jurisdiction in limited circumstances here under the Tucker Act was proper. Similarly, in *Erika, supra,* we concluded that a Part B provider may, if constitutional, statutory, or regulatory violations were alleged, sue in this court as to adverse reasonable cost determinations for post-1973 periods, notwithstanding that such an action was not specified in the relevant version of 42 U.S.C. § 1395ff and would have otherwise been barred by the language of 42 U.S.C. § 405(h). The contrary result, as in *Whitecliff,* would have prevented all review of a very large category of determinations. *Erika, supra* at ____, 634 F. 2d at 586-587. *See generally Overlook Hospital, supra; Appalachian Regional Hospitals, Inc.* v. *United States,* 217 Ct. Cl. 1, 576 F. 2d 858 (1978).

Reduced to essentials, then, the present case requires us to ascertain whether the pre-1973 statute "provides for review" of adverse coverage determinations. If so, under *Whitecliff* we must conclude that we are precluded from hearing this controversy.

Under the Medicare statutes, coverage determinations are governed by 42 U.S.C. §§ 1395d and 1395y. Section 1395d specifies the benefits covered by Medicare Part A: in-patient hospital services, post-hospital extended care services, and post-hospital home health services, and further provides annual day or visit limits for each. Section 1395y is applicable to both Parts A and B of Medicare and by its terms excludes certain services from the broad allowances of 42 U.S.C. § 1395d. The most important exclusions from coverage are expenses "which are not

reasonable and necessary for the diagnosis or treatment of illness or injury * * *," 42 U.S.C. § 1395y(a)(1), or which are for "custodial care," 42 U.S.C. § 1395y(a)(9).

Reasonable cost determinations, as involved in *Whitecliff* and *Erika,* on the other hand, are governed by the relevant version of 42 U.S.C. § 1395x(v) and the regulations thereunder. In determining reasonable cost of services under Part A, HEW makes allocations based on the proportion of charges made with respect to Medicare beneficiaries to all charges for that provider's services. See 20 C.F.R. §§ 405.452 (1972). HEW also makes reasonable cost determinations based on the various types of services provided Medicare beneficiaries and the various classes of institutions or agencies which are providers, 42 U.S.C. § 1395x(v).

This careful distinction between coverage determinations and reasonable cost determinations continues in the provision detailing determinations and appeals, 42 U.S.C. § 1395ff. Subsection (c) of that section provides:

> (c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Thus, a *provider* is granted a hearing and judicial review only in limited situations under Part A: (1) when provider status is contested, or (2) when the Secretary seeks to terminate the provider agreement, as for noncompliance. Under 42 U.S.C. § 1395ff(b), a beneficiary is entitled to a hearing and review in far broader circumstances:

> (b) Any individual dissatisfied with any determination under subsection (a) of this section as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

A beneficiary, therefore, may contest Part A and Part B adverse coverage ("entitlement") determinations and ultimately receive judicial review on such determinations, without limitations on amount under pre-1973 law.[8] As to Part A reasonable cost ("amount of benefits") determinations, a hearing would only be available when the amount in controversy exceeds $100 and judicial review available only when the amount exceeds $1,000. No hearing or judicial review is available under the pre- or post-1973 statutory scheme to a beneficiary contesting a Part B reasonable cost determination.

Also of relevance is 42 U.S.C § 1395cc(a)(1)(A). All providers must file an agreement (the so-called Medicare contract) with the Secretary of HEW to participate in the Medicare Part A program. 42 U.S.C. §§ 1395f(a) and 1395cc(a). Under 42 U.S.C. § 1395cc(a)(1)(A), a provider must agree

> not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made

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[8] *See, e.g., Bohlen* v. *Weinberger,* 483 F. 2d 918, 921, 922 nn.14-16 (3d Cir. 1973); *Ridgely* v. *Sec'y of Health, Education and Welfare,* 475 F. 2d 1222, 1223, 1224 (4th Cir. 1973); *Himmler* v. *Weinberger,* 422 F. Supp. 196, 200-201 (E.D. Mich. 1976); *Cardno* v. *Finch,* 311 F. Supp. 251 *passim* (E.D. La. 1970).

> under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title).

A provider is thereby prohibited from charging a beneficiary for the unreasonable portion of covered services but is *not prohibited* from charging a beneficiary for services which are not covered by Medicare. *See Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger,* 517 F. 2d 329, 339-340 n. 18 (5th Cir. 1975), *on request for rehearing,* 522 F. 2d 179, 180, *cert. denied,* 425 U. S. 935 (1976). Similarly, under the post-1973 provisions applicable to Part B, a provider can receive payments under Medicare only when the 42 U.S.C. § 1395cc(a) agreement (including a 42 U.S.C. § 1395cc(a)(1)(A) provision) has been filed. See 42 U.S.C. § 1395n(a) (Supp. III 1973) and present version.

Thus, when this portion of the Medicare statute is reduced to essentials, it becomes apparent that adverse reasonable cost determinations under either Part A or Part B cannot be passed along to the beneficiary once the Government obtains repayment from the provider. As the provider has no right under the statute to bring an action contesting the adverse reasonable cost determinations, it follows that the loss from both Part A and B reasonable cost determinations is left completely on the provider without an opportunity for judicial review. Beneficiaries, although possessing the technical right to have judicial review of Part A amount determinations if in excess of $1,000, would have little if any reason to do so when they do not bear the economic loss associated with the decision. Without an opportunity for review, the loss falls with finality. Faced with that finality, *Whitecliff, Erika,* and similar cases concluded that 42 U.S.C. § 405(h) should not apply to reasonable cost determinations with the same breadth as the *Salfi* Court had applied it to other Social Security Act determinations. Thus, limited review was allowed.

As to pre-1973 adverse Part A coverage determinations, however, the statutes we have detailed above have a far different impact. Although the provider is also denied the right to contest the initial adverse coverage decision, the pre-1973 statutes do not require that the economic loss caused by an adverse coverage determination remain with the provider. The provider may, under the statute, recover any loss associated with adverse coverage determinations from the beneficiary as the provider makes no agreement under 42 U.S.C. § 1395cc(a)(1)(A) to not pursue collection from the patient. Faced with the loss from the transaction, of course, the beneficiary has a significant economic incentive to contest the adverse determination before the Secretary and, if necessary, to seek judicial review under 42 U.S.C. §§ 1395ff(b) and 405(g). It is the beneficiary, not the provider, who under the statute is to bear the final loss caused by adverse coverage determinations; and the statute affords that loss-bearing beneficiary a right to review. We cannot say that Congress has not provided for review of adverse coverage determinations such as the ones of which these providers complain. Plainly, Congress intended that pre-1973 coverage disputes would be resolved in a manner different from that applicable to reasonable cost disputes and provided the means, a pass through of the loss associated with an adverse coverage determination to those with the statutory right to seek hearings and, if necessary, bring suit. In such circumstances, of course, where Congress has provided a method for review, *Whitecliff* and its progeny require that we respect that choice.

The plaintiffs suggest that this court "must" have jurisdiction over this case in that "[t]he Fifth Circuit transferred this case here precisely because it held that this Court does have jurisdiction. *Alabama Hospital Assn.* v. *Califano,* 587 F. 2d 762 (5th Cir. 1979)." This contention, of course, must be rejected for it is axiomatic that we may evaluate our jurisdiction at any time, notwithstanding what other courts, in dicta or otherwise,

may have suggested. *See Aetna Casualty & Surety Co.* v. *United States,* Ct. Cl. No. 454-79C (slip op. of June 17, 1981, at ____); *Berdick* v. *United States,* 222 Ct. Cl. ____, ____, 612 F. 2d 533, 536 (1979), and cases cited thereat.

Plaintiffs' briefs focus considerable attention on the allegedly unconstitutional nature of recoupment without a due process hearing. As we conclude we are without jurisdiction under the statutory scheme to hear any of plaintiffs' claims, those constitutional challenges are beyond our jurisdiction. Thus, although plaintiffs have not done so expressly, their briefs suggest another argument, viz., that the legislative scheme of 42 U.S.C. §§ 405(h), 405(g), 1395ff(b), and 1395ff(c), insofar as it precludes constituional challenges to coverage determinations, is unconstitutional. See *Johnson* v. *Robison,* 415 U.S. 361, 366-367 (1974).

We find this argument unpersuasive. Clearly, the legislative scheme those statutes provide does not preclude *all* constitutional challenges for those provisions do not limit the type of challenge a beneficiary may bring. An argument that 42 U.S.C. § 405(h) and related provisions is unconstitutional, then, must lie on an assumption that the Medicare provisions, by allowing payment directly to these providers, confer on those providers an interest which the providers alone can protect. The statute, however, is quite clear, both expressly in 42 U.S.C. § 1395gg(a) and implicitly in the provisions discussed above, that payment to a provider is to be regarded "as a payment to such individual [the beneficiary]" and is made as such. Moneys paid under the Medicare scheme to these providers are only paid conditionally, subject to administrative redetermination, including recoupment. *See generally Mount Sinai Hospital, supra.* Payment directly to the provider (rather than to the beneficiary and then to the provider) is apparently little more than an administrative convenience. We recognize, of course, these plaintiffs are far happier to collect as an initial matter from the United States, rather than from individual beneficiaries after repayment is

compelled. *Id.* at 335. We think that, however, is an inadequate basis on which to conclude the legislative scheme, as interpreted, is unconstitutional.[9] Had the statute required that Part A payment be made to the *beneficiaries,* these plaintiffs could not seriously assert that the Constitution accords them as *providers* a right to judicial review of a decision denying Medicare coverage to a beneficiary, even though such a determination might make ultimate collection by the providers more difficult. *Cf. O'Bannon* v. *Town Court Nursing Center,* 447 U. S. 773 (1980) (third parties indirectly affected by Government regulation have no due process right to contest the action). It would be incongruous for us to conclude the Constitution accords the providers a right to judicial review of Part A adverse coverage determinations merely because payment is first made for convenience to the providers. The statute clearly allows constitutional challenges by those for whose benefit the payment is made, and we think that adequate.[10]

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[9] Nor does *Langhorne Gardens, Inc.* v. *Weinberger,* 371 F. Supp 1216 (E.D. Pa. 1974), convince us otherwise. *Langhorne Gardens* determined that adverse Part B coverage determinations threaten a "substantial" interest of the provider, and thus an administrative hearing must at some point be afforded. The Government distinguishes that decision in that "the difference in cost and coverage procedures in Part A * * * are [sic] not present in Part B. *See* [*Szekely* v. *Florida Medical Association,* 517 F. 2d 345, 347-348 (5th Cir. 1975), *cert. denied,* 425 U. S. 960 (1976)]. * * *" The *Langhorne Gardens* decision did not, and could not, reach the issue before us, whether the legislative perclusion of judicial review is constitutionally permissive. After careful consideration, we decline to adopt the broad reading of *Langhorne Gardens* and *Mount Sinai Hospital* whch plaintiffs urge.

[10] Concededly, the import of today's decision and that of the Fifth Circuit decision earlier in this litigation is that the providers are unable, in their own stead, to challenge either the adverse coverage determinations or the constitutionality of the recoupment procedures. That result, as the text discusses, is itself constitutional and is mandated by the Medicare statutes as they read during the relevant periods. If there is inequity or unfairness in this result, it is for the Congress, and not this court, to remedy.

In *Salfi,* the Supreme Court concluded that 42 U.S.C. § 405(h) was not constitutionally invalid as applied to the Social Security Act, even though that provision precluded constitutional challenges other than those brought under 42 U.S.C. § 405(g). We find the following remarks of particular relevance and adopt them as our own:

> There is another reason why *Johnson* v. *Robison* is inapposite. It was expressly based, at least in part, on the fact that if § 211(a) reached constitutional challenges to statutory limitations, then absolutely no judicial consideration of the issue would be available. Not only would such a restriction have been extraordinary, such that "clear and convincing" evidence would be required before we would ascribe such intent to Congress, 415 U. S., at 373, but it would have raised a serious constitutional question of the validity of the statute as so construed. *Id.,* at 366-367. In the present case, as will be discussed below, the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus the plain words of the third sentence of § 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to nonconstitutional claims arising under the Act. The result is not only of unquestionable constitutionality, but it is also manifestly reasonable, since it assures the Secretary the opportunity prior to constitutional litigation to ascertain, for example, that the particular claims involved are neither invalid for other reasons nor allowable under other provisions of the Social Security Act. [422 U. S. at 762.]

See also O'Bannon v. *Town Court Nursing Center,* 447 U. S. at 797-798 (concurrence of Blackmun, J.); *Whitecliff,* 210 Ct. Cl. at 58 n.7, 536 F. 2d at 350-351 n.7.

These Medicare claims are, at a minimum, founded on statute and contract and thus literally within the Tucker Act. We conclude, however, that the statute does provide a method of review for Part A coverage disputes, viz., suit by the *beneficiary*. Under our prior decisional law, this action, brought by the *providers*, must therefore be dismissed. We further conclude that the legislative scheme of 42 U.S.C. §§ 405(h), 405(g), 1395ff(b), and 1395ff(c) is constitutional for an avenue of constitutional challenge is available to those possessing the true economic interest granted by the statute, the beneficiaries. Although not specifically addressed in this opinion, we have considered each of plaintiffs' contentions and reject them.

CONCLUSION

Based on the foregoing, plaintiffs' motion for summary judgment must be and is hereby denied. Defendant's alternative cross motion for summary judgment must be and is hereby allowed. Defendant's motion for judgment on the pleadings is denied as moot. The petition is dismissed.

APPENDIX B

IN THE UNITED STATES COURT OF CLAIMS

October 2, 1981

Order

PER CURIAM: IT IS ORDERED that the motions of the parties, as set forth below, for rehearing *en banc*, rehearing, reconsideration, to alter, amend or vacate judgments and orders of the court and relief therefrom, or for other relief pursuant to Rules 7(d), 151(b) and 152 are DENIED:

* * * *

465-79C ALABAMA HOSPITAL ASSOCIATION, ET AL.

Plaintiffs' motion to alter or amend judgment, filed June 29, 1981.

[KASHIWA, BENNETT and SMITH, *Judges*]

[Opinion of June 17, 1981]

* * * *

APPENDIX C

Opinions and Judgement of the U.S. Court of Appeals for the Fifth Circuit

Alabama Hospital Association, a Non-Profit Corporation, et al., Plaintiffs-Appellees Cross-Appellants,

v.

Joseph Califano, Jr., Secretary of Health, Education and Welfare of the United States, et al., Defendants-Appellants Cross-Appellees.

No. 76-4076

United States Court of Appeals, Fifth Circuit

January 12, 1979

Appeals from the United States District Court for the Middle District of Alabama.

Before Wisdom, Godbold and Tjoflat, Circuit Judges.

Per Curiam:

Alabama Hospital Association, an organization representing 140 Alabama hospitals, and the Tallapoosa County Hospital Board, as representatives of all private proprietary nonprofit and non-federal governmental hospitals located with Alabama, sued the Secretary of Health, Education and Welfare (HEW) and Blue Cross and Blue Shield of Alabama for alleged violations of the Due Process clause of the Fifth Amendment. The lawsuit arose out of HEW's recoupment of reimbursement funds paid to provider hospitals for medical services that Blue Cross, plaintiffs' fiscal intermediary, unilaterally determined were unnecessary. The plaintiffs contend that they were con-

stitutionally entitled to a hearing at some point during or after the recoupment process. The district court agreed. Jurisdiction to hear the case was based on 5 U.S.C. §§ 701-706 and 28 U.S.C. § 1331(a). We conclude that the district court acted without subject matter jurisdiction and we vacate its decision.

[1, 2] There was clearly no jurisdiction under 5 U.S.C. §§ 701-706, better known as § 10 of the Administrative Procedure Act. *Califano* v. *Sanders,* 430 U.S. 99, 107, 97 S.Ct. 980, 985, 51 L.Ed.2d 192, 200-01 (1977). Nor under this court's decisions in *Dr. John T. MacDonald Foundation* v. *Califano,* 571 F.2d 328 (CA5) (en banc), *cert. denied,* ____ U.S. ____, 99 S.Ct. 250, 58 L.Ed.2d 238 (1978), and *American Association of Councils of Medical Staffs* v. *Califano,* 575 F. 2d 1367 (CA5), *pet. for cert. filed,* 47 U.S.L.W. 3267 (U.S. Oct. 3, 1978), was there jurisdiction under 28 U.S.C. § 1331(a).

MacDonald involved a challenge by a provider of Medicare services to HEW's method of determining reimbursable cost. On the basis of *Weinberger* v. *Salfi,* 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), this court concluded that the incorporation of 42 U.S.C. § 405(h) into the Medicare Act through 42 U.S.C. § 1395ii, eliminated subject matter jurisdiction under 28 U.S.C. § 1331(a) to review the validity of HEW's reimbursement procedures. That decision controls this case. The plaintiffs argue that *MacDonald* can be distinguished because § 405(h)'s bar to jurisdiction applies only to appeals from findings and decisions of the Secretary, and here the plaintiffs sued because HEW held no hearing. But this court decided in *American Association of Councils of Medical Staffs* v. *Califano, supra* at 1372, that the lack of an "administrative hearing or decision . . . does not serve as a relevant distinction from *MacDonald.*" *Id.* at 1372; *accord, Trinity Memorial Hospital* v. *Associated Hospital Services,* 570 F.2d 660, 667 (CA7, 1977).

[3] We have held that Medicare plaintiffs whose claims are barred by § 405(h) may go to the Court of Claims. *American Association of Councils of Medical Staffs* v. *Califano, supra* at 1373; *Dr. John T. MacDonald Foundation* v. *Califano, supra* at 332.[1] The Court of Claims does not have the power to grant the plaintiffs' request for declaratory and injunctive relief, but it can decide the issue raised by the plaintiffs because they have requested damages. *See American Association of Councils of Medical Staffs* v. *Califano, supra* at 1373.

VACATED and REMANDED to the district court for dismissal without prejudice to the plaintiffs to file other appropriate proceedings.

Alabama Hospital Association, a Non-Profit Corporation, et al., Plaintiffs-Appellees, Cross-Appellants,

v.

Joseph A. Califano, Jr., Secretary of Health, Education and Welfare of the United States, et al., Defendants-Appellants, Cross-Appellees

No. 76-4076

United States Court of Appeals, Fifth Circuit

February 26, 1979

Appeals from the United States District Court for the Middle District of Alabama; Frank M. Johnson, Jr., Chief Judge.

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[1] The Court of Claims held in *Whitecliff, Inc.* v. *U. S.*, 536 F.2d 347 (Ct.Cl. 1976), *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977), that its jursidction was not affected by § 405(h).

Before Wisdom, Godbold and Tjoflat, Circuit Judges.

By the Court:

IT IS ORDERED that appellee's motion to alter or amend judgment is GRANTED. The last paragraph of our opinion filed January 12, 1979, is deleted and in lieu thereof the following is substituted:

> Pursuant to 28 U.S.C. § 1406(c), the appeal is DISMISSED and the cause is TRANSFERRED to the Court of Claims. *See Dr. John T. MacDonald Foundation* v. *Califano,* 571 F.2d 328 (CA5) (en banc), *cert. denied,* ____ U.S. ____, 99 S.Ct. 250, 58 L.Ed.2d 238 (1978).

APPENDIX D

Opinion and Judgment of the U.S. District Court for the Middle District of Alabama

In the United States District Court for the Middle District of Alabama, Northern Division

Civil Action
No. 74-394-N

Alabama Hospital Association, a Non-profit Corporation; and Tallapoosa County Hospital Board, Inc. (operating East Tallapoosa Hospital), a Public Corporation,
Plaintiffs,

v.

F. David Mathews, as Secretary of Health, Education and Welfare of the United States; and Blue Cross and Blue Shield of Alabama, a non-profit corporation,
Defendants.

Memorandum Opinion

(Filed August 23, 1976)

In this class action, plaintiffs seek declaratory and injunctive relief, and damages for deprivation of their right to due process under the Fifth Amendment. Jurisdiction in this matter is pursuant to 28 U.S.C. §§ 1331(a), 2201, and 2202 and 5 U.S.C. §§ 701-706.

By joint motion of the parties, the case is being submitted to the Court for decision on the basis of the briefs and the evidence presented by stipulations, affidavits, answers to interrogatories and other documents of the parties.

Plaintiffs are the Alabama Hospital Association, an organization comprised of approximately 140 hospitals in the State of Alabama, and the Tallapoosa County Hospital Board, Inc., which operates a hospital in Dadeville, Alabama. Plaintiff Tallapoosa County Hospital Board sues on its own behalf, and each plaintiff sues on behalf of all private non-profit, private proprietary, and non-federal governmental hospitals located in Alabama with the exception of the Hospital Association of Conecuh County.

Defendants are F. David Mathews, the Secretary of the Department of Health, Education and Welfare (hereinafter HEW), and Blue Cross and Blue Shield of Alabama (hereinafter Blue Cross). The Department of Health, Education and Welfare is charged with the administration of the Medicare Act, which is the subject of this dispute. It has delegated certain of its responsibilities to Blue Cross.

Under the "Medicare Act,"[1] a hospital may enter into an agreement with HEW to become a provider of medical services ("provider") for beneficiaries of the Medicare program. When the hospital provides the services, then it looks to HEW for payment. In this case, all of HEW'S financial dealings with the plaintiff hospitals were through a "fiscal intermediary," defendant Blue Cross. In the performing of its function, Blue Cross conducted an audit and review of past reimbursements made to providers in Alabama, and determined that some reimbursements had been made for medically unnecessary services. This determination was made on a unilateral basis. As a result, defendants demanded that the alleged overpayments be returned to them, and threatened to withhold future payments if they were not. Under this pressure, some providers repaid the money, while others had admittedly due payments withheld. The total amount in dispute is $656,571.18.[2]

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[1] 42 U.S.C. §§ 1395, *et seq.*

[2] The parties have stipulated the amount in dispute with regard to each member of the plaintiff class.

The "Medicare" Act incorporates several provisions of the Social Security Act.[3] One of these incorporated provisions, Section 405(h), states that "No findings of fact or decisions of the Secretary [of HEW] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under [§§ 1331, *et seq.*] of Title 28 to recover on any claim arising under this subchapter."[4] The Social Security Act provides procedures for review,[5] including judicial review, and the Medicare Act grants dissatisfied beneficiaries the right to a hearing and judicial review.[6] However, at no time relevant to this case was there any specific provision which gave hospitals, such as plaintiffs, the right to review. Defendants therefore maintain that, in the absence of such a provision, the specific prohibition of Section 405(h) deprives this Court of jurisdiction to hear the case, even though this would leave plaintiffs without a judicial remedy.

Defendants rely principally on the Supreme Court decision in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975). That case involved a challenge to a Social Security requirement brought under the jurisdiction of Section 1331. The Court said that Section 405(h) barred the district court from taking jurisdiction in the case. However, the Supreme Court emphasized that the act had provided the plaintiff with another procedure to raise his chailenge, and thus that judicial review was not precluded. In fact, the Court said "clear and convincing" evidence of congressional intent would be required before a statute would be construed to eliminate judicial review. And in the present case, defendants' interpretation would eliminate judicial review.

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[3] Subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of 42 U.S.C. § 405 are incorporated into the "Medicare" Act by 42 U.S.C. § 1395(ii).

[4] 42 U.S.C. § 405(h).

[5] 42 U.S.C. § 405(b) and (g).

[6] 42 U.S.C. § 1395(ff).

To find that plaintiffs are without a judicial remedy would indeed raise serious constitutional problems.[7] Two Second Circuit decisions, announced before *Weinberger* v. *Salfi, supra,* held that this was not Congress's intent. *Kingsbrook Jewish Medical Center* v. *Richardson,* 486 F.2d 663 (2d Cir. 1973); and *Aquavella* v. *Richardson,* 437 F.2d 397 (2d Cir. 1971), involved suits by providers against HEW. These decisions said that the bar to district court jurisdiction contained in Section 405(h) only applied where, as in Social Security cases, there was some other type of remedy. As there were no other remedies, Medicare providers were permitted to proceed under 28 U.S.C. § 1331.

This question has now been settled in the Fifth Circuit. *Dr. John T. MacDonald Foundation, Inc.* v. *Mathews,* No. 75-2966 (5th Cir., May 12, 1976) (slip opinion), which was decided after *Weinberger* v. *Salfi, supra,* declined to apply that decision to a situation where a provider hospital had no other opportunity for judicial review. The Court stated, "The law of this circuit, then, is that § 405(h) is not an absolute bar to jurisdiction under the APA to review refusals of the Secretary to reopen decisions otherwise unreviewable." Thus, the jurisdiction of this Court to hear a constitutional challenge to the defendants' action is clear.

The defendants had a right, in the present case, to withhold payment to the hospitals in order to recover the overpayments made in the past. The Fifth Circuit has held that "the government's common law right to recoup is available to HEW in its implementation of the Medicare hospital insurance program to recover from providers funds paid for medically unnecessary services." *Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger,* 517 F.2d 329 (5th Cir. 1975).

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[7] *See Johnson* v. *Robinson,* 415 U.S. 361 (1974); and Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts: An Exercise in Dialectic,* 66 Harv. L. Rev. 1362.

The remaining issue is whether the Due Process Clause of the Fifth Amendment requires that provider hospitals be given a hearing, at least after a recoupment. *Coral Gables Convelescent Hone, Inc.* v. *Richardson,* 340 F. Supp. 646 (S.D. Fla. 1972) has held that this is indeed necessary. And defendants have conceded that in disputes with HEW, the providers have a right to a hearing. Defendants' principal contention is based on the face that the hospitals may still charge their patients for any services that the Medicare program does not pay. As a result, the defendants argue, the only people suffering any real loss are the patients, and the hospitals cannot assert the patients' rights for them. According to this theory, plaintiffs have no property interest for the Fifth Amendment to protect and thus they have no standing.

Under *Board of Regents* v. *Roth,* 408 U.S. 564 (1972), a plaintiff must have a substantial property interest (if he has no life or liberty interest) in order to invoke the protection of Due Process.[9] However, obtaining payment from the defendants rather than having to try to collect from numerous individuals of uncertain location and financial condition, many of whom may in fact be dead, is a substantial interest. *Langhorne Gardens, Inc.* v. *Weinberger,* 371 F.Supp. 1216 (E.D. Penn. 1974). The court in *Langhorne Gardens* said that it could not "characterize as *de minimus* the substitution of individual medicare patients for the Federal Government as financial obligor for medical services rendered." It further stated that the hospital had "a substantial interest in perfecting its claims against the Government." The district court in *Coral Gables Convalescent Home, Inc.* v. *Richardson, supra,* though not confronted with the *de minimus* argument presented here, did hold that due process required a hearing upon request for a provider hospital claiming money from the Medicare program. In that case, as in the present one, HEW claimed that the hospital had been overpaid and deducted these amounts from later payment.

[9] In *Roth,* the Fourteenth Amendment was involved.

As the Court finds that the hospitals are asserting a substantial property interest of their own, defendants' lack of standing argument necessarily fails. Defendants further argue that all sums paid back by the hospitals, under threat of HEW's withholding future funds, were voluntarily paid. This contention is without merit. See *Robertson* v. *Frank Bros.*, 132 U.S. 17 (1889); *Swift Co.* v. *United States*, 111 U.S. 22 (1883).

This Court now concludes that defendants' exercise of their right of recoupment without giving the provider hospitals a hearing at some point was a violation of procedural due process. Therefore it will be necessary for defendants either to pay to the plaintiffs the disputed amounts or to undertake evidentiary hearings within a reasonable time.

An order will be entered accordingly.

Done, this the 23rd day of August, 1976.

/s/ Frank M. Johnson, Jr.
United States District Judge

In the United States District Court for the Middle District of Alabama, Northern Division

Civil Action
No. 74-394-N

Alabama Hospital Association, a Non-profit Corporation; and Tallapoosa County Hospital Board, Inc. (operating East Tallapoosa Hospital), a Public Corporation,
Plaintiffs,

v.

F. David Mathews, as Secretary of Health, Education and Welfare of the United States; and Blue Cross and Blue Shield of Alabama, a non-profit corporation,
Defendants.

Judgment

(Filed August 23, 1976)

Pursuant to the findings of fact and conclusions of law set forth in the memorandum opinion made and entered in this case this date, it is the ORDER, JUDGMENT and DECREE of this Court that:

1. Judgment be and is hereby entered in favor of the plaintiffs.

2. Defendants F. David Mathews and Blue Cross and Blue Shield of Alabama be ENJOINED from failing to either (a) repay any and all sums recouped in this case [in accord with the stipulations of the parties]; or (b) institute evidentiary hearings within a reasonable time to determine the propriety of defendants' recouping any and all funds not repaid to plaintiffs.

3. Defendants shall notify the Court and plaintiffs within 30 days whether or not they intend to pay plaintiffs any of the disputed sums. If they give notice of an intention to pay any of said sums, then they shall pay within 60 days thereafter.

4. Should defendants give notice of an intention to conduct evidentiary hearings, then all parties shall submit to the Court within 90 days any and all objections to the evidentiary hearings being conducted according to the rules, standards, and procedures set out in 42 U.S.C. § 1395 (oo) and to said hearings being conducted before the Provider Reimbursement Review Board established by that section. If no objections are filed, then any hearings shall be so conducted.

5. The costs in this proceeding be and are hereby taxed against the defendants.

Done, this the 23rd day of August, 1976.

/s/ Frank M. Johnson, Jr.
United States District Judge

APPENDIX E

Stipulation of the Parties
(Exhibit X Omitted)

The parties stipulate that the "Medicare Act", as defined in the complaint, which was relevant and controlling in all of the transactions which are the subject of this litigation was this Medicare Act in the form prior to the amendments effective October 31, 1972, and that none of the provisions contained in these 1972 amendments applied to the transactions in this case.

The parties have previously agreed by stipulation filed November 11, 1975, that:

> "The parties, by and through their attorneys of record, stipulate that this action is properly maintainable and may proceed as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure, on behalf of all affected private non-profit, private proprietary and non-federal governmental hospitals located and operating in the State of Alabama with the exception of Hospital Association of Conecuh County, a corporation d/b/a Conecuh County Hospital; and the parties further stipulate that the named plaintiffs in this action are proper representatives to maintain the aforesaid class action."

The hospital class members are private non-profit, private proprietary and non-federal governmental hospitals operating and located within the State of Alabama. All of these hospitals provided medical services for which they sought reimbursement from defendant Blue Cross, as fiscal intermediary for the Secretary of HEW under the Medicare Act. Following reimbursement, the defendant fiscal intermediary, after fiscal review and audit, determined that there had been an over payment to those class members and in the amounts specified in Exhibit X, because of over utilization of hospital services by patients in these hospitals. Patient files were reviewed by registered nurse

employees of the fiscal intermediary and its medical consultants; and the fiscal intermediary made a unilateral determination of whether the entire hospital stay was or was not reasonable and necessary, or whether part of it was and part of it was not. To the extent that the fiscal intermediary determined that payments, as reimbursement for hospital care, had been made to these class members for hospital services thus determined to be unnecessary, the fiscal intermediary sought repayment of those amounts. As an alternative repayment by these hospitals, defendants asserted the right of recoupment against future requests for reimbursement for future hospital services provided by them.

The essential issue for decision by the Court is whether the procedures utilized by defendants in making these determinations were wrongful and illegal for the reasons asserted by the plaintiffs in the complaint; or were proper as asserted by defendants.[1] Subsumed under this issue are the questions—(a) was there a hearing which comported with constitutional and statutory requirements; and (b) were constitutionally and statutorily adequate standards applied?

In the conduct of fiscal review and audit procedure of the class members shown on Exhibit X, defendants took the position that they could determine unilaterally whether these class members had received medicare reimbursements to which they were not entitled. The defendants, in the course of the retroactive denial of benefits, furnished to these class members the names of those patients who were deemed to have been unnecessarily treated or to have been the recipients of noncoverage services. Notwithstanding requests by these class

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[1] In view of the holding in *Mt. Sinai Hospital, etc.* v. *Weinberger, etc.*, 517 F.2d 329 (5th Cir. 1975), the parties assume that this Court is bound thereby to find available to defendants the remedies of recoupment and offset, provided the procedures utilized did not violate the constitutional and statutory rights of the hospital class members.

members for hearing or review of these adverse determinations of defendants, the determinations were made unilaterally by defendants; defendants did not grant hearings or review procedures in connection with or after adverse determinations of over payment to these class members, and the assertion of the right to recoupment or offset from or against them. Defendants took the position that such unilaterial determinations of over payments, without opportunity for hearing and review, were contemplated under and by the Medicare Act; and, moreover, that there was no provision in the Medicare Act or regulations promulgated thereunder for hearing or review prior to or after an administrative determination of over payment and of a right to recoupment and offset.

On the question of the adequacy of the procedure, plaintiffs assert that a failure to provide a hearing or review, in and of itself, deprives the affected class members of their constitutional and statutory rights as specified in the complaint. Defendants contend that there is no constitutional or statutory infirmity in the procedures which they employed. Plaintiffs, by submission on this stipulation, do not waive their right to contend further that the standards applied by defendants did not meet constitutional and statutory requirements; but feel that it is not necessary for the Court to reach this point in view of their contentions that the absence of hearing or review procedure is infirmity enough to warrant relief. Should the Court find it necessary to reach the question of adequate standards, further testimony will have to be developed.

Defendants have also asserted that the repayments actually made by class members were made voluntarily. The basis of this characterization is contained in the Levine affidavit. Plaintiff class members assert that the repayments were made under duress, and thus not voluntarily, and rely on the affidavits of G. C. Long and Frank Gittings. Defendants do not dispute the recitations in the Long and Gittings affidavits that repayments

were made by class members after threat by defendants to withhold future payments until the alleged over payments had been recouped.

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Opposition

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No. 81-875

In the Supreme Court of the United States

OCTOBER TERM, 1981

ALABAMA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether the Court of Claims had jurisdiction under the Tucker Act, 28 U.S.C. 1491, of a suit brought by providers of services under Part A of the Medicare program, as that program existed prior to its amendment in 1972, seeking reimbursement for services that were determined not to be covered by Medicare.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinion of the Court of Claims (Pet. App. A-1 to A-20) is reported at 656 F.2d 606. The earlier opinion of the United States Court of Appeals for the Fifth Circuit (Pet. App. A-23 to A-26) is reported at 587 F.2d 762, and this Court's denial of certiorari on that occasion is reported at 444 U.S. 826.

JURISDICTION

The judgment of the Court of Claims was entered on June 17, 1981. A timely petition for rehearing (Pet. App. A-21) was denied on October 2, 1981.

The petition for a writ of certiorari was filed on November 10, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

STATUTES INVOLVED

The statutory provisions involved are reprinted at Pet. 2-3.

STATEMENT

1. Under Part A of the Health Insurance for the Aged Act, 42 U.S.C. (& Supp. III) 1395 *et seq.*, commonly known as the Medicare program, eligible beneficiaries are insured for the cost of hospital and related post-hospital services[1] that they receive from hospitals and other institutions that qualify as "provider[s] of services" under 42 U.S.C. 1395x(u). The costs of these services are paid for by the Secretary of Health and Human Services through a fiscal intermediary, usually a health insurance company such as Blue Cross and Blue Shield of Alabama, a co-defendant in this case. 42 U.S.C. 1395h.

In administering the Part A program, the fiscal intermediary is responsible for determining whether the medical services provided to an individual Medicare beneficiary are of the type generally covered by Part A and are not excluded from coverage because, *e.g.*, they "are not reasonable and necessary for the diagnosis or treatment of illness or injury * * *." 42 U.S.C. 1395y(a)(1).

Although payment for covered services is made directly to the provider, 42 U.S.C. 1395f(a), the Act makes clear that the payment nevertheless is solely on behalf of the beneficiary:

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[1] Supplementary services, primarily physicians' services, are covered by Part B of the Medicare program, 42 U.S.C. 1395j-1395w. This case concerns only Part A benefits.

> Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

42 U.S.C. 1395gg(a). If the fiscal intermediary determines that the services provided a beneficiary are not covered by Part A of Medicare, the provider may charge the beneficiary for the services. 42 U.S.C. 1395cc(a)(1)(A); Pet. App. A-15; *Mt. Sinai Hospital* v. *Weinberger*, 517 F.2d 329, 339-340 n.18 (5th Cir.), on petition for rehearing, 522 F.2d 180 (1975), cert. denied, 425 U.S. 935 (1976).

If the intermediary determines that particular services are not covered by Part A, the beneficiary (who persumably would be liable to the hospital under state contract law for the cost of the services rendered) has the right to an administrative hearing by the Secretary and to judicial review of the intermediary's decision denying coverage. 42 U.S.C. 1395ff.[2] During the periods relevant to this case, providers were not entitled to an administrative hearing or to judicial review of an intermediary's decision denying coverage, because the beneficiary was ultimately liable for payment in such circumstances.

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[2] As we explain in our brief in *United States* v. *Erika, Inc.*, No. 80-1594 (at 28-30), an ambiguity in the language of Section 1395ff prior to 1972 led some courts to conclude that a beneficiary could obtain a hearing and judicial review of adverse coverage determinations without meeting any jurisdictional amount requirements. See Pet. App. A-14; 42 U.S.C. (1970 ed.) 1395ff(b). Since 1972, the Act expressly has provided that an administrative hearing is available only if the amount in controversy is at least $100 and that judicial review is available only if the amount in controversy is at least $1,000. 42 U.S.C. 1395ff(b). The present case concerns only the now-superseded pre-1972 language.

In 1972, however, the Act was amended to grant providers the same right to an administrative hearing and judicial review that the beneficiary has if the Secretary determines that the beneficiary will not exercise the right to a hearing and judicial review under Section 1395ff(b) on his own behalf. See 42 U.S.C. 1395pp(d). This section applies only to services furnished after October 30, 1972, and therefore does not apply to this case. Pub. L. No. 92-603, Section 213(b), 86 Stat. 1386.

If the intermediary determines that services are covered by Medicare, it then must determine the reimbursable reasonable cost of the services. 42 U.S.C. 1395x(u), 1395h. If the amount of reimbursement paid by the intermediary to the provider for particular covered services is less than the amount claimed by the provider, the provider cannot recover the difference from the beneficiary. 42 U.S.C. 1395cc (a)(1)(A). Thus, the beneficiary may be held responsible for the cost of services that are found not to be covered by Medicare; but where the services are covered by Medicare, the hospital or other provider is responsible for absorbing the loss if the intermediary determines that the reimbursable reasonable cost for a particular service is less than the amount claimed by the provider. Pet. App. A-14 to A-15.

The intermediary does not make a final settlement and payment of each claim on an individualized basis when it is submitted. Rather, funds are paid to the provider at least monthly to cover the estimated cost of all services furnished by the provider to Medicare beneficiaries during that period. 42 U.S.C. 1395g(a); 42 C.F.R. 405.405(a) (1980). The final determination of the actual reimbursement due is then made at the end of the accounting period, after the pro-

vider's total costs for the period are allocated between its Medicare and non-Medicare patients, according to HHS regulations. See 42 C.F.R. 405.404, 405.405, 405.415 *et seq.* (1980). After this process is completed, subsequent monthly payments to the provider are adjusted to correct for past overpayments and underpayments. 42 U.S.C. 1395g(a); 42 C.F.R. 405.405(c) (1980). Essentially the same regulations were in effect during the time when the present case arose. See 20 C.F.R. Part 405 (1972).

Finally, at the time this case arose, as now, regulations promulgated by the Secretary provided that before the fiscal intermediary could suspend payments to a provider in order to recoup for a past overpayment, it had to notify the provider in writing of the suspension, give its reasons for the action, and allow the provider time to submit a statement in response. 20 C.F.R. 405.371 (1973). If it sustained the suspension, the intermediary had to give written notice of its decision, including "specific findings" and "an explanatory statement." 20 C.F.R. 405.372 (1973). Compare 42 C.F.R. 405.371, 405.372 (1980).

2. a. In 1972, Blue Cross and Blue Shield of Alabama, the fiscal intermediary for Alabama provider hospitals, conducted a review of services previously furnished by the hospitals to Medicare patients for which reimbursement already had been made. It determined in a number of cases that the service provided was not medically necessary, and it notified the hospitals of its decision to recoup these overpayments from future Medicare payments to the hospitals. The majority of hospitals decided to repay the amounts in question, and the overpayments to the remainder of the hospitals were deducted from future payments to those hospitals (Pet. App. A-4 to A-5).

b. Rather than seeking to recover from the patients at that point, thereby creating an occasion for the patients to request an administrative hearing under 42 U.S.C. 1395ff(b) of the intermediary's decision denying coverage, petitioners filed suit against the Secretary and the fiscal intermediary in the United States District Court for the Middle District of Alabama. They alleged that the Secretary and the intermediary had deprived them of property without due process of law by not furnishing the opportunity for an evidentiary hearing to challenge the determination that the particular services were not covered by Part A. In an opinion dated August 23, 1976, the district court concluded that the providers were entitled to such a hearing and ordered the Secretary and the intermediary either to repay the amounts in question or to provide "evidentiary hearings within a reasonable time" (Pet. App. A-33).

c. The court of appeals reversed, holding that the district court lacked jurisdiction of the case. The court reasoned that under 42 U.S.C. 405(h) and 1395ii (see Pet. 2), a district court is precluded from exercising jurisdiction over any case arising under the Medicare Act except as provided in the Act itself. Because no provision of the Medicare statute conferred jurisdiction in this case, the court of appeals concluded that jurisdiction was barred. In so holding, the Fifth Circuit followed its prior decision in *Dr. John T. MacDonald Foundation* v. *Califano*, 571 F.2d 328, cert. denied, 439 U.S. 893 (1978), in which it had held that the Medicare Act forecloses jurisdiction in federal district court of suits by providers challenging Medicare Part A reimbursement decisions (Pet. App. A-23 to A-25). As it had done in *MacDonald*, however, the court of ap-

peals ordered the case transferred to the Court of Claims pursuant to 28 U.S.C. 1406(c), because that court previously had held that it has jurisdiction under the Tucker Act, 28 U.S.C. 1491, to hear Medicare claims that are not reviewable under the judicial review provisions of the Medicare Act itself. Pet. App. A-25 to A-26; *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977). The hospitals' petition for a writ of certiorari was denied. 444 U.S. 826 (1979).

d. The Court of Claims concluded that its jurisdictional holding in *Whitecliff* did not apply here and that it therefore did not have jurisdiction of the instant case under the Tucker Act. The court reiterated its observation in *Whitecliff* that it has jurisdiction under the Tucker Act where the Medicare Act forecloses "all review" and accords "absolute finality" to the intermediary's decision, but that "[w]here the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations" rather than bringing suit in the Court of Claims under the Tucker Act (Pet. App. A-10 to A-12, quoting *Whitecliff, Inc.* v. *United States*, *supra*, 536 F.2d at 351). In *Whitecliff*, the court noted, the provider challenged the intermediary's pre-1973 reasonable cost determinations, for which, at that time, the Medicare Act provided no right to an administrative hearing or judicial review,[3] even though the provider had to absorb the loss occasioned by the intermediary's determination that the reasonable cost of Part A services was less

[3] In 1972, the Act was amended to furnish providers with a right to administrative and judicial review of an intermediary's reasonable cost determinations. See 42 U.S.C. 1395*oo*.

than the amount claimed by the provider. See Pet. App. A-12 to A-15. In contrast, the court observed (*id.* at A-14 to A-16), the provider is entitled to charge the beneficiary for services found by the intermediary not to be covered by Part A, and the Medicare Act does provide for review of an intermediary's decision denying coverage by furnishing the *beneficiary* with a right to an administrative hearing and judicial review in such circumstances. Because the Medicare Act itself provides for judicial review of coverage disputes, the court held that it did not have jurisdiction of the same issues under the Tucker Act.

The court emphasized that its jurisdictional holding did not raise any constitutional difficulty—*i.e.*, by leaving a party without a judicial forum in which to litigate a constitutional claim—because the Act does not "confer on * * * providers an interest which the providers alone can protect" (Pet. App. A-17). In the Court of Claims' view, the statute is "quite clear * * * that payment to a provider is to be regarded 'as a payment to such individual [the beneficiary]' and is made as such" (*ibid.*, quoting 42 U.S.C. 1395gg(a)). Thus, the court reasoned, "[p]ayment directly to the provider (rather than to the beneficiary and then to the provider) is apparently little more than an administrative convenience," and "[m]oneys paid under the Medicare scheme to these providers are only paid conditionally, subject to administrative redetermination, including recoupment" (*id.* at A-17). Although the court appreciated that petitioners might prefer to collect from the United States rather than from individual beneficiaries after the intermediary determines that the services were not covered, this preference did not, in the court's view, render the statutory scheme un-

constitutional. "The statute clearly allows constitutional challenges by those [the beneficiaries] for whose benefit the payment is made, and we think that adequate" (*id.* at A-18).

ARGUMENT

The decision of the Court of Claims that it did not have jurisdiction under the Tucker Act over petitioners' reimbursement claim is correct and does not conflict with any decision of this Court or the courts of appeals. Moreover, the decision below is of no continuing importance, because the Medicare Act was amended in 1972 to afford providers with a right to an administrative hearing and judicial review on coverage questions. Nor is the result below unfair, because petitioners presumably had, but did not pursue, a cause of action under state law against the individual patients who received the services for which payment under the Medicare program was denied. Review by this Court therefore is unwarranted.

1. a. The Court of Claims correctly concluded that it did not have jurisdiction of the instant case under the Tucker Act. In *Whitecliff, Inc.* v. *United States*, *supra*, the Court of Claims held that it has jurisdiction of Medicare claims under the Tucker Act whenever the Medicare Act itself does not provide for such review. 536 F.2d at 351. The Court of Claims acknowledged in *Whitecliff* (*id.* at 350) that the bar to judicial review in Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), is made applicable to the Medicare program "to the same extent" as it is applicable with respect to Title II of the Social Security Act. See 42 U.S.C. 1395ii. The second sentence of Section 205(h) provides that "[n]o findings

of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided" (emphasis added). Because, prior to the 1972 amendments, the Medicare Act did not provide for judicial review of the calculation by a fiscal intermediary, on behalf of the Secretary, of the reasonable cost of Part A services, the second sentence of Section 205(h) barred such review in any "tribunal," including the Court of Claims. Thus, as we argue in our brief in *United States* v. *Erika, Inc.*, No. 80-1594 (to be argued Mar. 1, 1982) (at pages 35-38), the Court of Claims erred in concluding in *Whitecliff* and its subsequent decision in *Erika* v. *United States*, 634 F.2d 580 (1980), that Section 205(h), as incorporated into the Medicare Act by 42 U.S.C. 1395ii, does not foreclose Tucker Act jurisdiction of Medicare claims.[4] If this Court agrees with our submission in *Erika*, then it is clear that the Court of Claims was without jurisdiction in the instant case.

b. However, the Court of Claims properly dismissed petitioners' claims even if, contrary to our submission above, that court's decisions in *Whitecliff* and *Erika* are correct. As the Court of Claims itself reasoned in the instant case (Pet. App. A-10 to A-12), *Whitecliff* involved a pre-1972 reasonable cost dispute, for which the Medicare Act did not furnish either the provider or the beneficiary a right of judicial review. *Erika* similarly involves an issue—the amount of reimbursement due for services covered by

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[4] In addition, the legislative history of the Medicare Act, discussed at pages 27-30 of our brief in *Erika*, also manifests a congressional intent to keep individual reimbursement disputes under both Part A and Part B of the Medicare program out of the courts, except where the Medicare Act expressly authorizes judicial review.

Part B of the Act—for which the Medicare Act itself does not provide judicial review. The issue in the instant case, in contrast, is whether certain services furnished to Medicare beneficiaries were covered by Part A of the Medicare program. When this case arose, the Act did provide a right to an administrative hearing and judicial review of such claims, at the request of the beneficiary. 42 U.S.C. (1970 ed.) 1395ff(b). Therefore, as the Court of Claims properly concluded (Pet. App. A-10 to A-16), the holdings in *Whitecliff* and *Erika* that Tucker Act jurisdiction will lie whenever the Medicare Act itself does not provide for judicial review are inapplicable here.[5] Because the Court of Claims decision in *Erika*, even if it were correct, does not control this case, there is no reason to hold the petition in the instant case pending this Court's decision in *Erika*.

c. There is an additional reason why certiorari is not warranted on the question of the Court of Claims' jurisdiction under the Tucker Act in this case. The Medicare Act was amended in 1972 to afford a provider the same opportunity for an administrative hearing and judicial review of coverage questions under Part A of the Medicare Act as is afforded to the beneficiary, if the Secretary determines that the beneficiary will not exercise those rights on his own

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[5] As the Court of Claims stated (Pet. App. A-16):

> Plainly, Congress intended that pre-1973 coverage disputes would be resolved in a manner different from that applicable to reasonable cost disputes and provided the means, a pass through of the loss associated with an adverse coverage determination to those with the statutory right to seek hearings and, if necessary, bring suit. In such circumstances, of course, where Congress has provided a method for review, *Whitecliff* and its progeny require that we respect that choice.

behalf. 42 U.S.C. 1395pp(d). For services provided after October 30, 1972, then, it is even clearer under the reasoning of the Court of Claims' decision in *Whitecliff* that there is no Tucker Act jurisdiction of coverage issues under Part A, because the Act contains its own provision for judicial review of such questions at the instance of providers such as petitioners. Thus, the decision below is of no continuing importance.

d. Finally, the Court of Claims clearly was correct in concluding (Pet. App. A-6) that it did not have jurisdiction over petitioners' claim for money damages for an alleged due process violation in the procedures followed by the intermediary. The Due Process Clause cannot be read to mandate monetary compensation whenever a violation occurs. *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976); *United States* v. *Testan*, 424 U.S. 392, 400 (1976).

2. Petitioners contend (Pet. 15-18), however, that the Court should grant certiorari in this case because the Court of Claims has held that all judicial review of their due process claim is barred. This argument fails for three reasons.

a. First, the Court of Claims' actual jurisdictional holding necessarily was limited to the narrow question of its own jurisdiction under the Tucker Act. See Pet. App. A-5 to A-16. That court could not "hold" that *all* judicial review of alleged denials of procedural due process is barred, even in the federal district courts. Petitioners previously had litigated the question whether the district court had jurisdiction of their due process claim; they lost in the court of appeals (Pet. App. A-23 to A-26), and certiorari was denied by this Court. To be sure, the combined *effect* of the decision below and the earlier decision of the Fifth Circuit is that neither the Court

of Claims nor the district court was found to have jurisdiction of petitioners' claims. But the actual holding of the court whose decision petitioners seek to have reviewed under 28 U.S.C. 1255(1) pertains only to the scope of the Court of Claims' jurisdiction under the Tucker Act.

b. Second, in response to the same argument when made below—*i.e.*, that a preclusion of all judicial review of coverage questions, even those raising constitutional issues, would be unconstitutional—the Court of Claims correctly concluded (Pet. App. A-17 to A-19) that the Act does not confer an interest on providers that only they can protect. If the Medicare Act had not been enacted, the patients who received the services for which petitioners seek reimbursement under Medicare presumably would be liable under state law for the cost of those services. Where the services are covered by Medicare and the provider has chosen to participate in the Medicare program, the Medicare Act in effect substitutes federal payment under that Act on behalf of the patient in place of patient liability under state law. Accordingly, although payment under Part A of the Medicare Act is made directly to providers of services, the Act expressly states that the payment "shall be regarded as a payment to [the beneficiary]." 42 U.S.C. 1395gg(a).

The Act's authorization of direct payment to providers is, in the words of the Court of Claims, "little more than an administrative convenience" (Pet. App. A-17). It is meant only to guarantee that, if payment is approved, it will in fact reach the hospital and not be diverted by the patient, as well as to reduce administrative processing expenses. However, where the fiscal intermediary determines that the services for which reimbursement is sought are not

covered by Medicare, the provider's state-law right to recover from the patient is reinstated. Concededly there may be practical advantages to a hospital in collecting directly from Medicare. But the mere fact that an intermediary's denial of coverage may have an adverse impact on the hospital by requiring it to recover from an individual patient who may, in some circumstances, be a less reliable debtor does not convert the hospital's interest in the coverage issue under Medicare into a distinct, constitutionally protected *property* right. See *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 787, 790 (1980).[6]

Petitioners appear to argue (Pet. 11-12, 18), however, that due process requirements came into play because the intermediary's decision that services were not covered was made after payment had been made to them, following the intermediary's review of earlier coverage determinations. But, as the Court of Claims held, "[m]oneys paid under the Medicare scheme to these providers are only paid conditionally, subject to administrative redetermination, including

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[6] In any event, due process is not a rigid concept, calling for a specific set of procedural rights in every situation. Rather, it is "flexible and calls for such procedural protections as the particular situation demands." *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972); see also *Cafeteria & Restaurant Workers* v. *McElroy*, 367 U.S. 886, 895 (1961); *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). Here, the providers were given notice and the right to submit a written response to the intermediary's decision to disallow coverage before that decision became final. 20 C.F.R. 405.371-405.372 (1973). Given the technical nature of questions of whether services were medically necessary, this right to submit a written response was sufficient process under the circumstances, especially in view of the fact that denial of coverage simply required petitioners to seek recovery from the patient rather than denying them a right of recovery altogether.

recoupment" (Pet. App. A-17). No reason appears why a provider has a due process right to a hearing merely because it has received a conditional payment. This view is consistent with that of the Fifth Circuit in *Mt. Sinai Hospital* v. *Weinberger*, *supra*, 517 F.2d at 338:

> [The] provision of services without payment by Medicare is exactly what happens no matter when HEW decides a service is not covered. Mount Sinai does not challenge the authority of the government to make its decision not to pay for a service after the performance of the service. * * * Whether payment is denied or payment is made and recoupment asserted, the hospital has already provided the services and suffers the same loss of compensation from the Medicare program for services rendered.[7]

c. Finally, the question whether Congress has foreclosed, or constitutionally could foreclose, all judicial review of Medicare reimbursement claims such as those raised by petitioners is of no continuing importance. As amended in 1972, the Act now furnishes

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[7] Contrary to petitioners' assertion (Pet. 8-9 n.15, 15), the Fifth Circuit did not hold in *Mt. Sinai* that a hospital has a property interest in receiving or retaining payments under Medicare. Indeed, at the passage cited, the Fifth Circuit observed that the coverage question was principally a matter between the beneficiary and the Secretary, although the court did observe that "[a]s a practical matter" the hospital is concerned with who the debtor is. 517 F.2d at 339. This Court made clear in *O'Bannon* that not every practical interest in a governmental decision rises to the level of a constitutionally protected property interest. Nor, contrary to petitioners' assertion (Pet. 8-9 n.15, 12-13, 15), did the Fifth Circuit hold in petitioners' case that they had a constitutionally protected property interest. The court of appeals did not consider that question.

a provider with a right to an evidentiary hearing in circumstances such as those presented here. 42 U.S.C. 1395pp(d). Moreover, although the Fifth Circuit and the Court of Claims have each concluded that it lacks jurisdiction over petitioners' cause of action, petitioners have been afforded a full opportunity to present the merits of their due process argument to a court. That argument has been addressed and rejected by the Court of Claims in the course of its holding that an absence of Tucker Act jurisdiction in this case did not result in an unconstitutional foreclosure of judicial review to a person who actually had a due process interest in the administrative determination. As a result, there is no occasion for this Court to intervene to assure an airing of petitioners' constitutional arguments.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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FEBRUARY 1982

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